Wyoming Department of Health

Nursing Home

Nursing Home overview and billing

How to Contact your Field Representative

- The Provider Outreach email address is the correct email for the Field Representatives
  - wyprovideroutreach@cns-inc.com
  - Attestations are also sent to this email address
- Claim Denials, Eligibility, and Prior Authorization questions can be completed through the Call Center
  - 1-888-996-6223

Course Content

- Prior Authorization Look up
- Member Eligibility
- Attestation and LT101
- PASRR Information and PASRR I submission
- Value Codes
- Billing Examples
- Top 5 common denials and how to resolve
- How to bill a straight claim
- Error Codes
- Adjustments

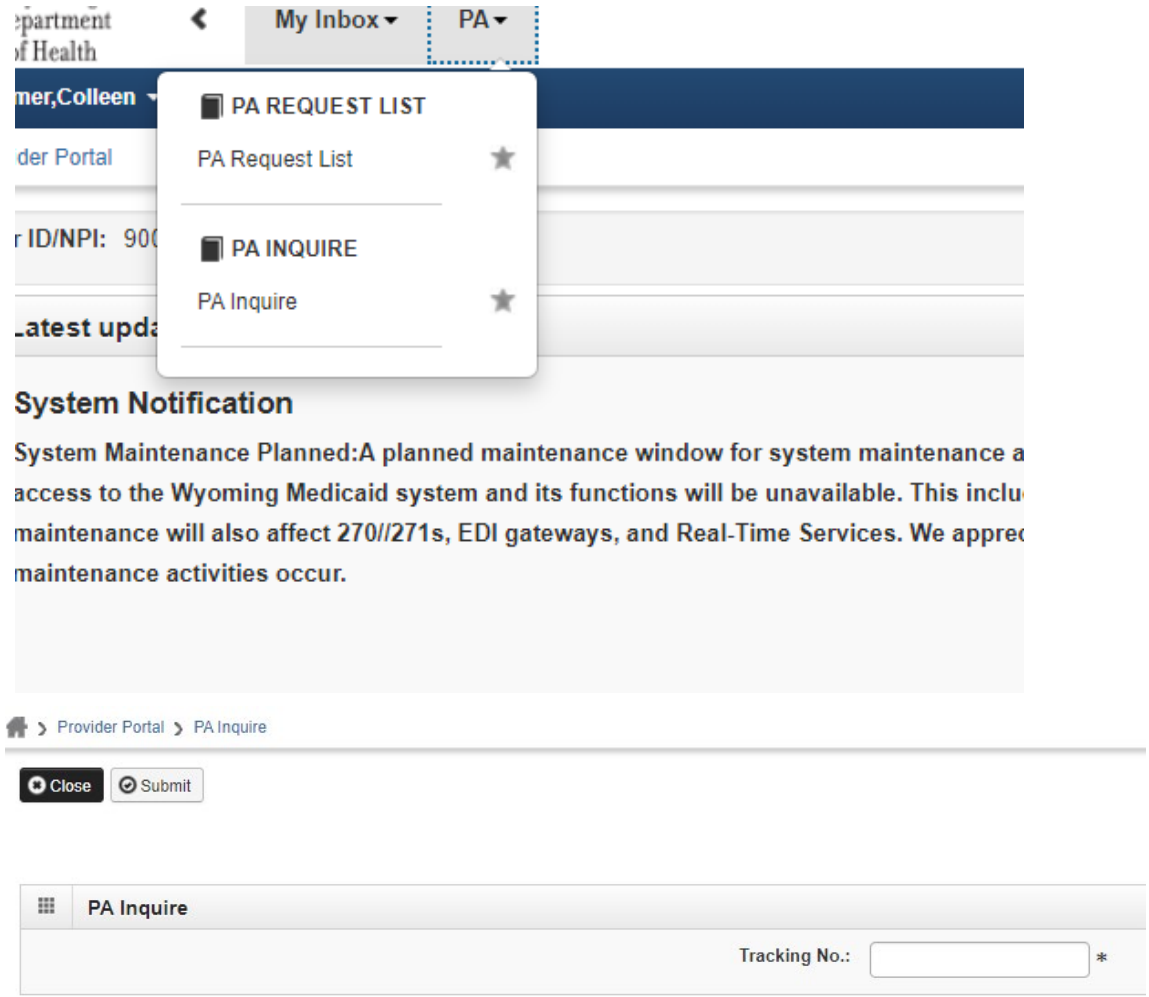
Prior Authorization

Searching and Seeing a Prior Authorization

Prior Authorization- Sign on

- Select the applicable domain from the Domain drop-down list
- Select Prior Authorization from the Profile drop-down list
- Select Go

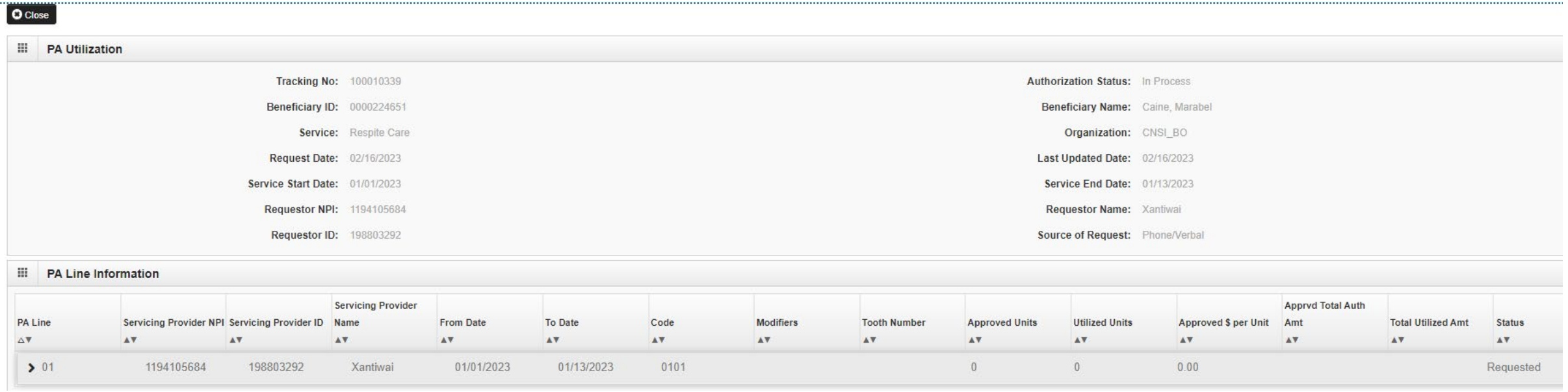
Prior Authorization- PA Inquire



When the PA tracking number is available:

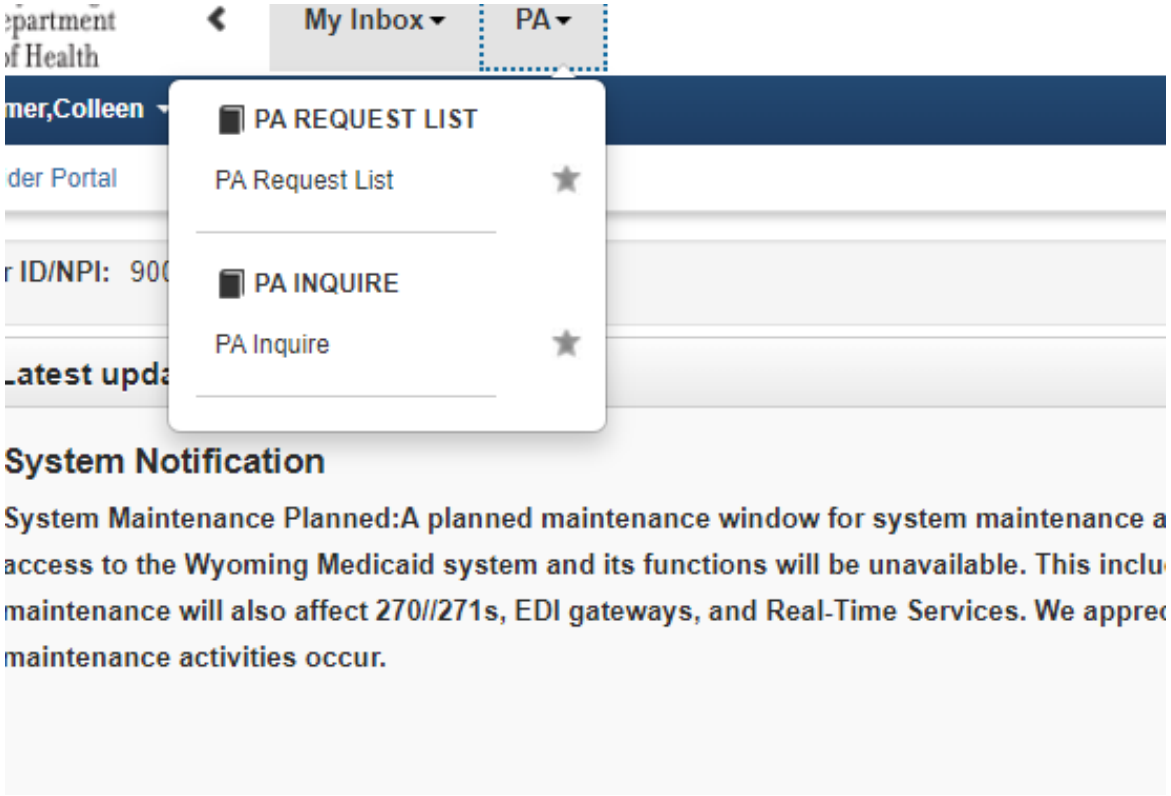
- Select PA at the top of the screen
- PA Inquire
- Enter tracking number
- Select Submit

PA Inquire- Search Results



- The statistical information is displayed
- TCN's that have been billed to the prior authorization will displayed

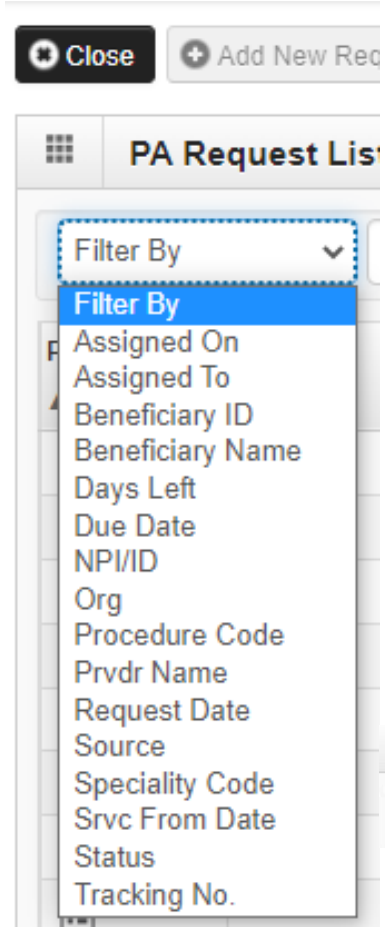
Prior Authorization- PA Request List

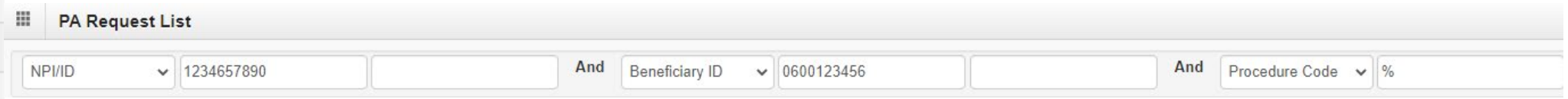


If the PA Tracking number isn't available:

- Choose PA at the top of the screen
- Select PA Request List

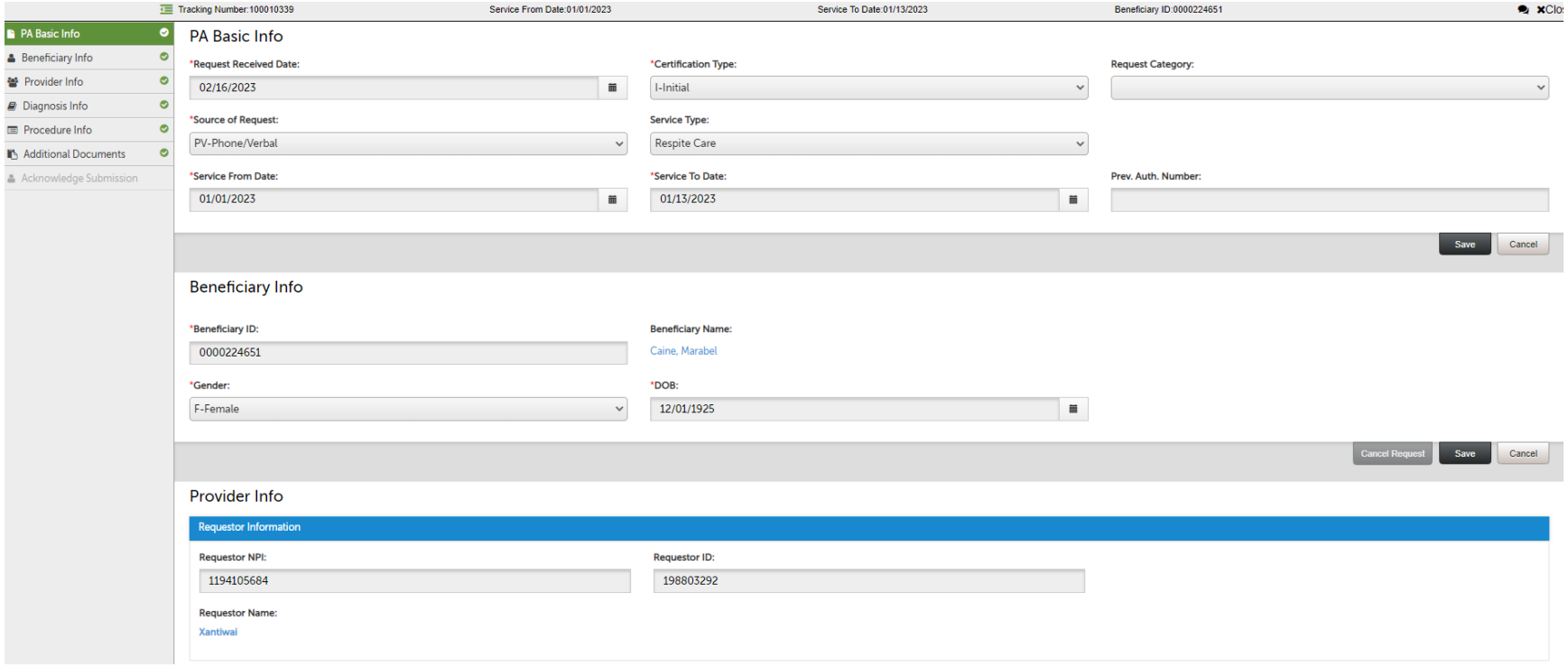
Prior Authorization- PA Request List- Filters





- Filters are available to help narrow PA population
- After searching all the prior authorization associated to the group will populate.
- Select the correct prior authorization

Prior Authorization- PA Request List- Reading the PA



- Alternative view of the PA, with the same information as PA Inquire
- “PA Basic Info” allows quick navigation through the PA

Member Eligibility

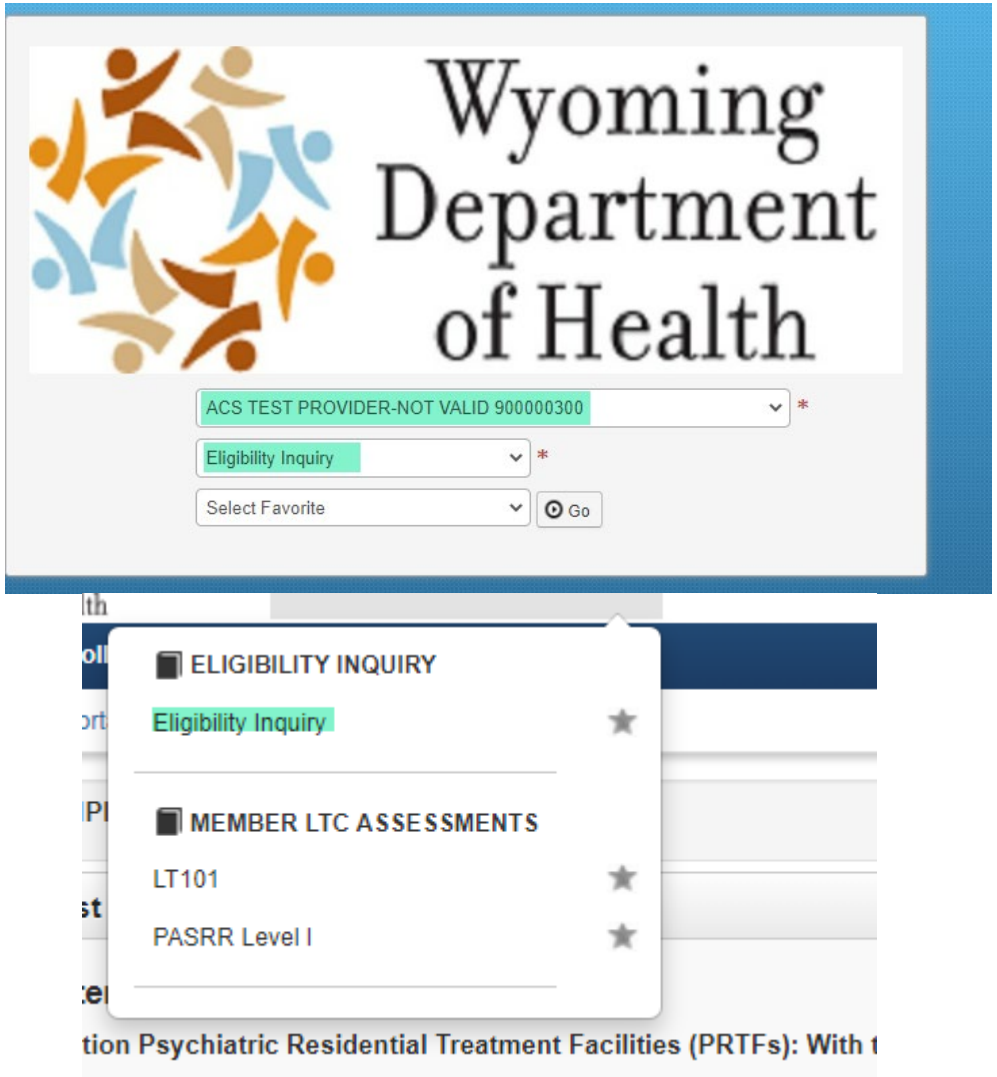
Reading Eligibility and Member Primary Insurance

Member Eligibility- Nursing Home Plans

Benefit plans that can bill Nursing home claims:

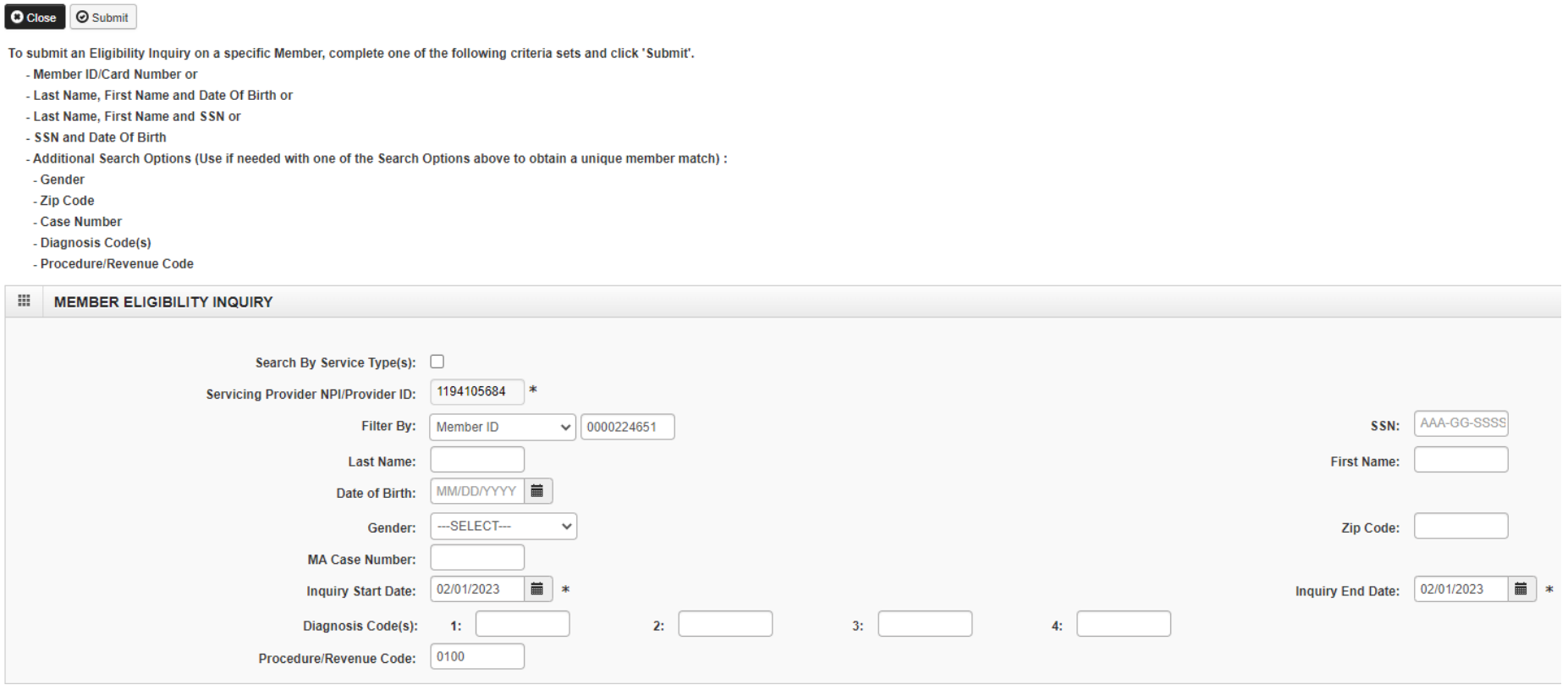
- NH (Nursing Home)
- CCW (Community Choice Waiver
- COAW (Comprehensive Adult Waiver plan)
- SUAW (Supports Adult Waiver)

Member Eligibility- Sign On



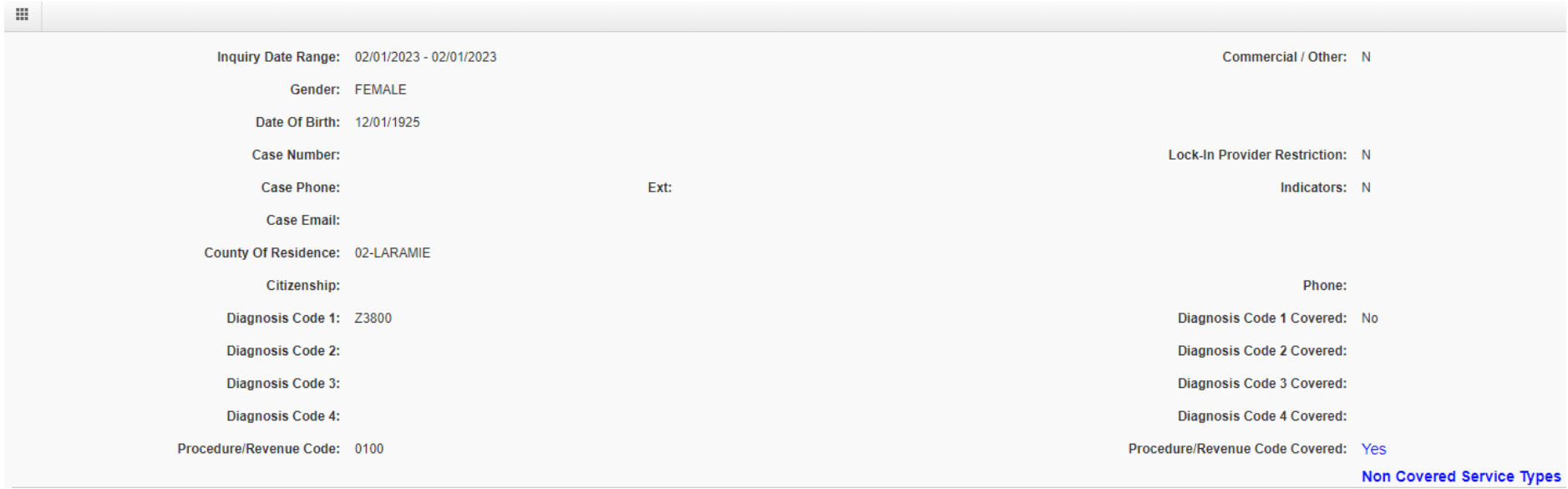
- Select “Eligibility Inquiry” for the domain
- Then once signed in:
  - Click Member
  - Click Eligibility Inquiry

Member Eligibility- Search



- Enter the Member's ID
- Enter the date for inquiry
- Enter Diagnosis or Revenue codes as applicable
- Click Submit

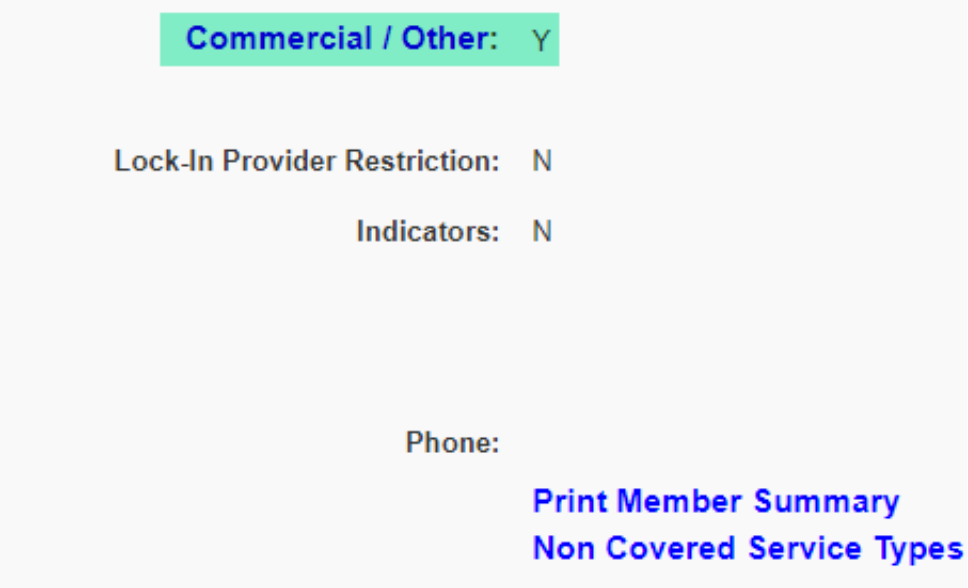
Member Eligibility- Member File



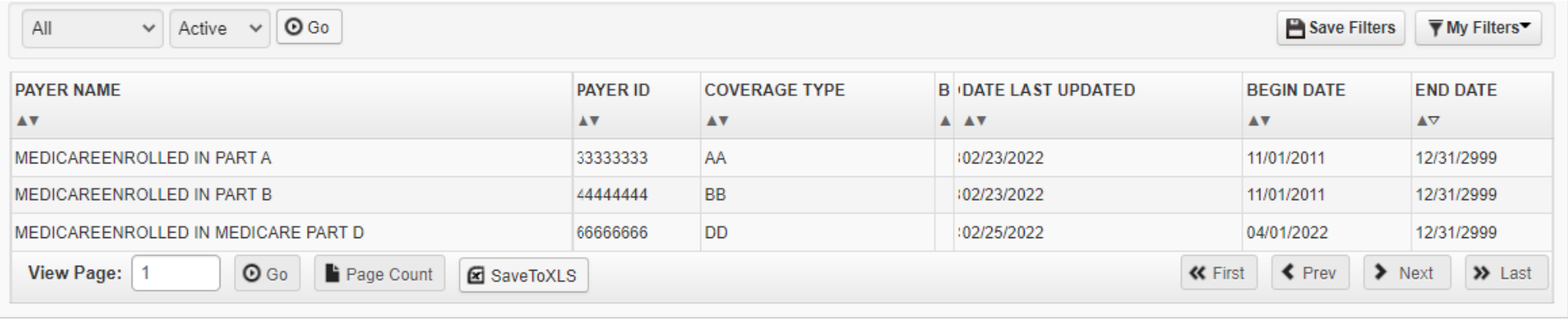
Inquiry Date Range:	02/01/2023 - 02/01/2023			Commercial / Other:	N
Gender:	FEMALE				
Date Of Birth:	12/01/1925				
Case Number:				Lock-In Provider Restriction:	N
Case Phone:		Ext:		Indicators:	N
Case Email:					
County Of Residence:	02-LARAMIE				
Citizenship:				Phone:	
Diagnosis Code 1:	Z3800			Diagnosis Code 1 Covered:	No
Diagnosis Code 2:				Diagnosis Code 2 Covered:	
Diagnosis Code 3:				Diagnosis Code 3 Covered:	
Diagnosis Code 4:				Diagnosis Code 4 Covered:	
Procedure/Revenue Code:	0100			Procedure/Revenue Code Covered:	Yes
					Non Covered Service Types

- Member specific information is displayed
- Hyper links are available for more specificity

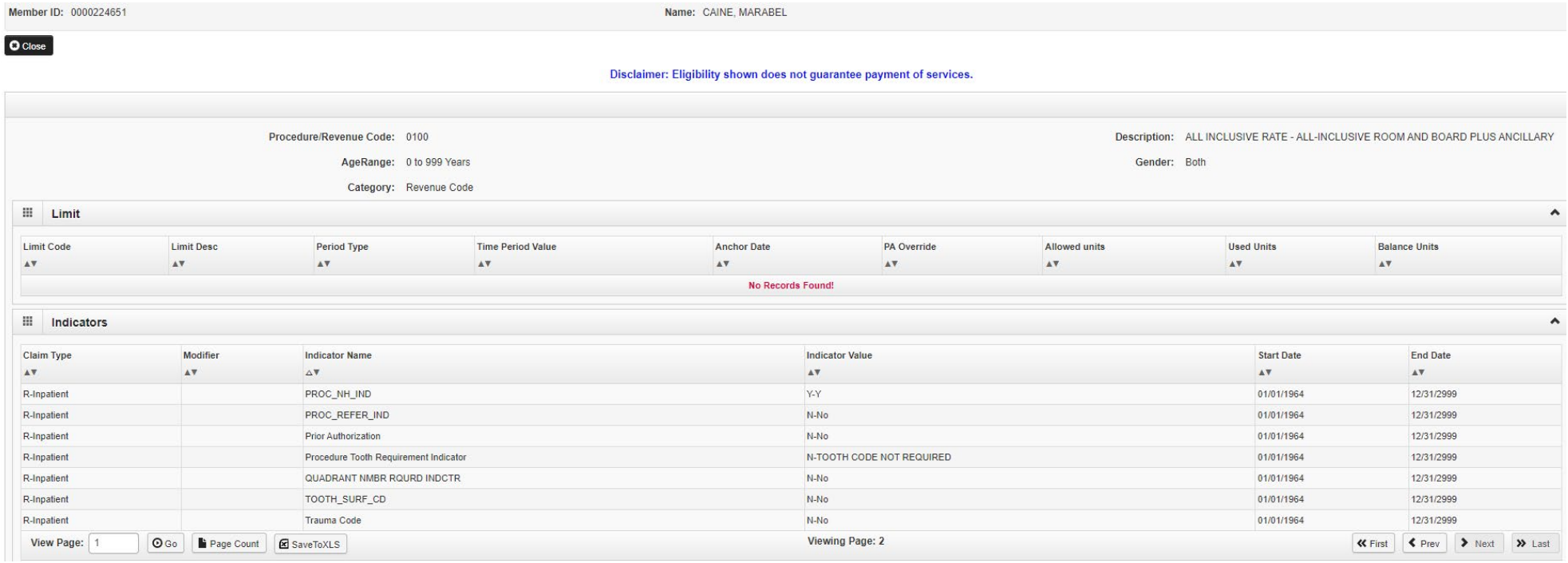
Member Eligibility- TPL (Primary Insurance)



- Choose “Commercial/ Other” when the indicator is Yes
- This will populate the commercial insurance for the member

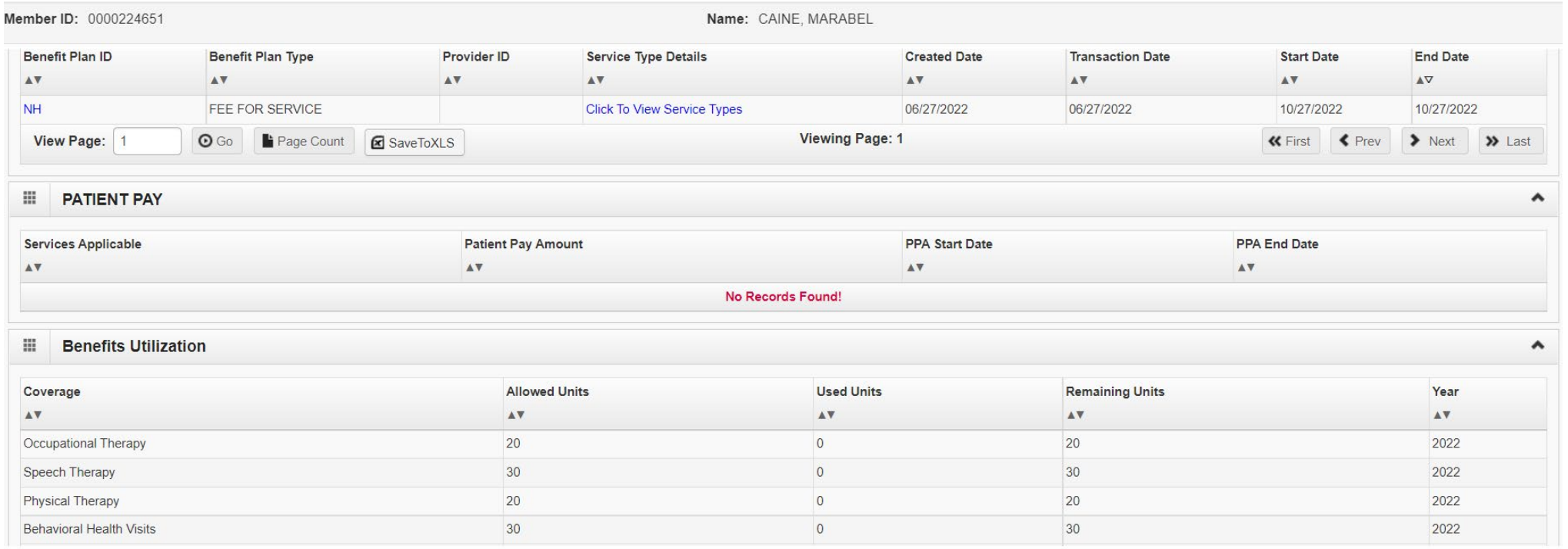


Member Eligibility- Code Information



- Click Yes on the Diagnosis Code/Revenue Code covered
- The display gives details about the code and indicators
- This is where prior authorization is indicated
- Information can be verified using the Fee Schedule that can be found on the main webpage

Member Eligibility- Member File



Member ID: 0000224651 **Name:** CAINE, MARABEL

Benefit Plan ID	Benefit Plan Type	Provider ID	Service Type Details	Created Date	Transaction Date	Start Date	End Date
NH	FEE FOR SERVICE		Click To View Service Types	06/27/2022	06/27/2022	10/27/2022	10/27/2022

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

PATIENT PAY

Services Applicable	Patient Pay Amount	PPA Start Date	PPA End Date
No Records Found!			

Benefits Utilization

Coverage	Allowed Units	Used Units	Remaining Units	Year
Occupational Therapy	20	0	20	2022
Speech Therapy	30	0	30	2022
Physical Therapy	20	0	20	2022
Behavioral Health Visits	30	0	30	2022

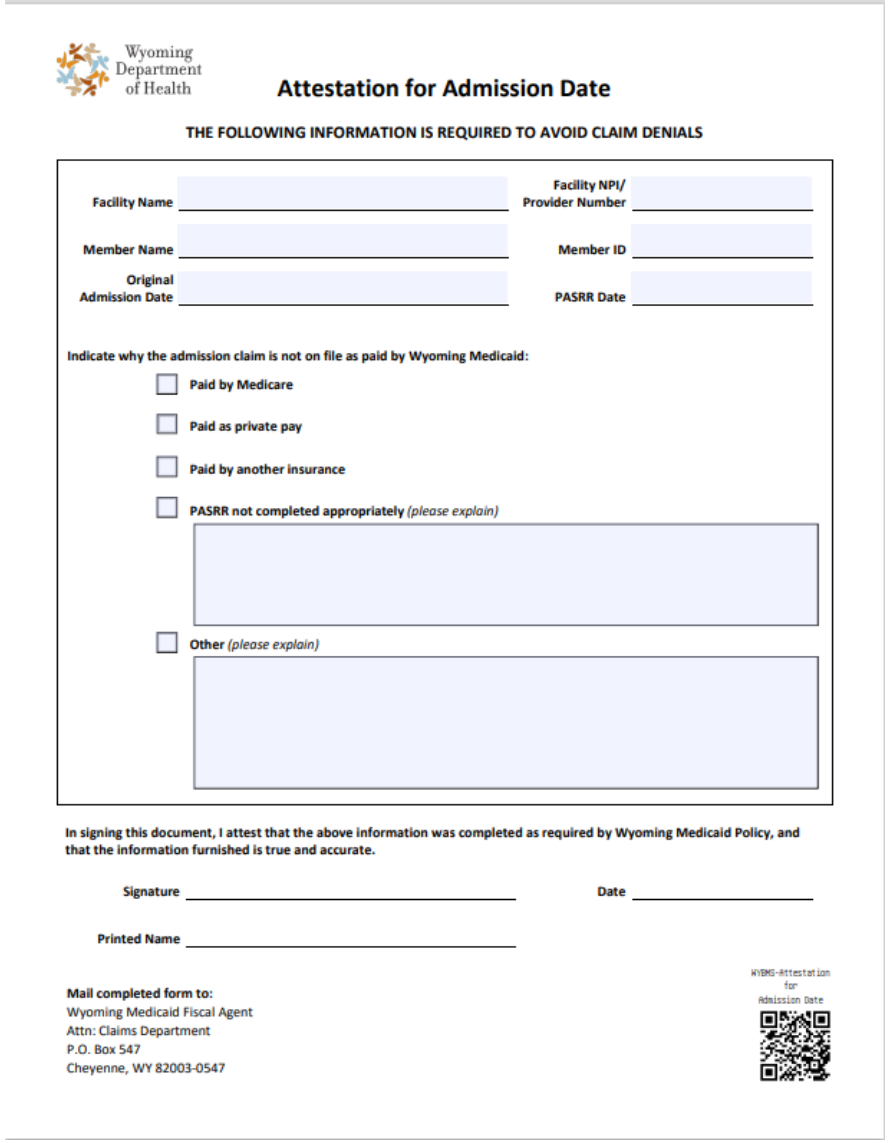
- Plan is noted on this part of the file.
  - When a plan is noted, the member is eligible for Medicaid

- Benefit utilization is also displayed here

Attestation and LT101

Attestation and LT101

Attestation form



Wyoming Department of Health

Attestation for Admission Date

THE FOLLOWING INFORMATION IS REQUIRED TO AVOID CLAIM DENIALS

Facility Name _____ Facility NPI/ Provider Number _____

Member Name _____ Member ID _____

Original Admission Date _____ PASRR Date _____

Indicate why the admission claim is not on file as paid by Wyoming Medicaid:

- ☐ Paid by Medicare
- ☐ Paid as private pay
- ☐ Paid by another insurance
- ☐ PASRR not completed appropriately *(please explain)*
- ☐ Other *(please explain)*

In signing this document, I attest that the above information was completed as required by Wyoming Medicaid Policy, and that the information furnished is true and accurate.

Signature _____ Date _____

Printed Name _____

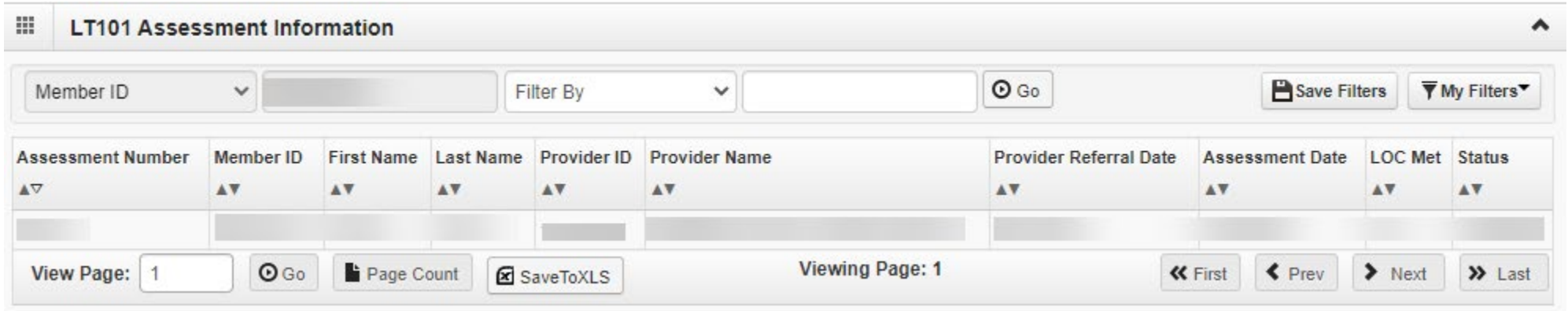
Mail completed form to:
Wyoming Medicaid Fiscal Agent
Attn: Claims Department
P.O. Box 547
Cheyenne, WY 82003-0547

WYDMS-Attestation for Admission Date

Attestation form:

- The Attestation form can be found at:
  - Attestation Form
- This is used when Medicaid doesn't pay the admit claim

LT101- List and information



- LT101's are valid for 1 Year (365 days)
- Gateway Login (wyo.gov)– This is the website to request LT101
- LT101's will be stored on the BMS (Provider Portal)
- Statistical information will be populated on the first screen

PASRR Level I and Screen for PASRR II

Completing a PASRR Level I and list for PASRR II

PASSR Level I- Manual Information

BEGINNING July 1, 2022, the PASRR process must be completed prior to admission of resident. This includes the PASRR Level I and if needed the PASRR Level II.

PASRR Level 1 – Pre-Admission Screening and Resident Review

- As a result of PASRR all applicants to Medicaid-certified nursing facilities must be screened for: Mental Illness (MI), Intellectual/Developmental Disability (ID/DD) or Related Condition (RC), regardless of funding and...
  - Known or suspected condition must trigger evaluation
  - To ensure appropriateness of NF placement
  - To ensure receipt of needed services
    Screens for potential diagnosis of mental illness or intellectual disability
- This is found in the manual in chapter : 19.3.4.2

PASRR Level I -Significant Change in Condition

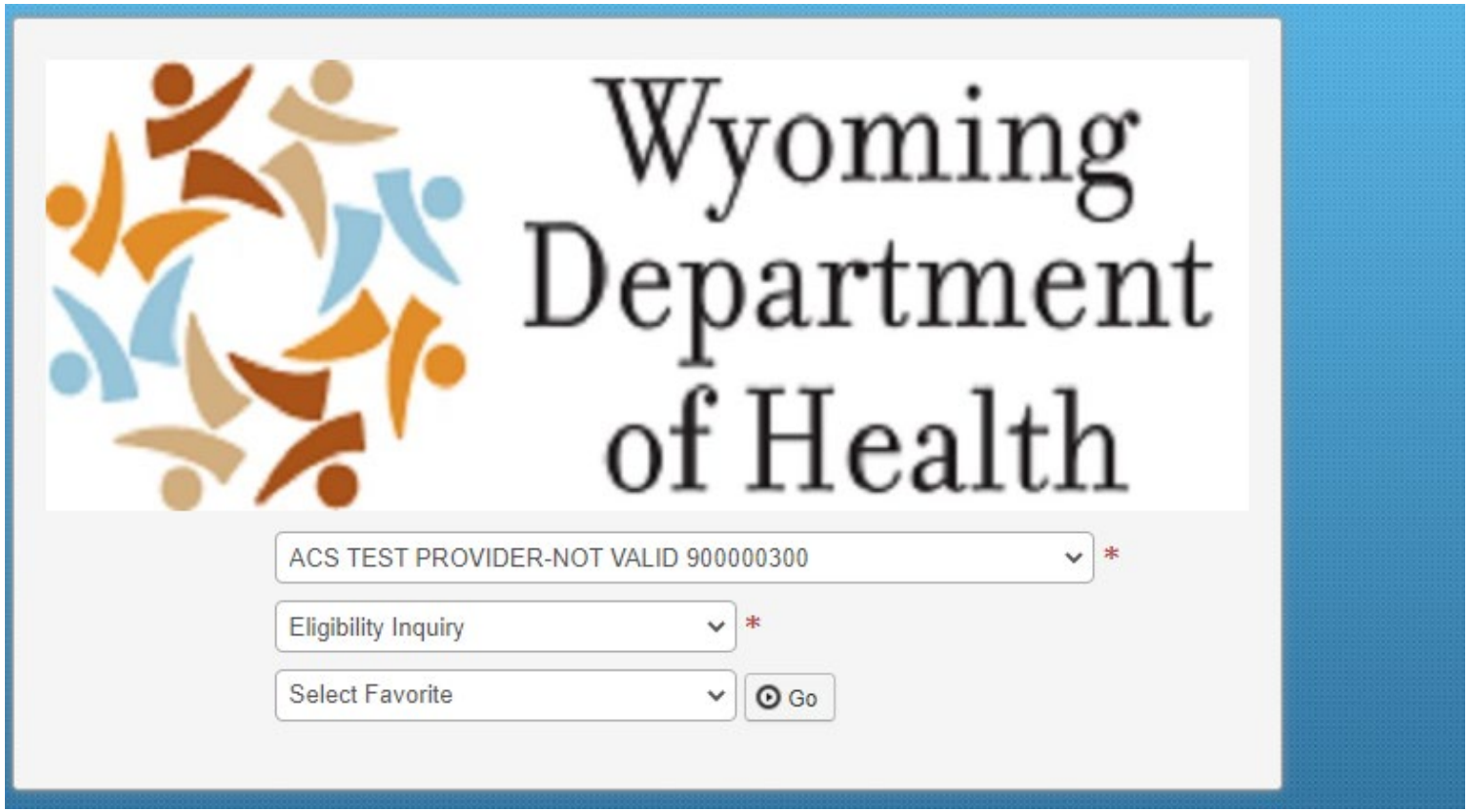
- A PASRR Level I Resident Review must be completed if there is a significant change in condition.
- A significant change in condition is defined as:
  - A condition that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions.
    - The decline is not considered “self- limiting”
- Impacts more than one area of the resident’s health status; and
- Requires interdisciplinary review and/or revision of the care plan.

PASRR Level I-ICD10data.com

- Diagnosis must be valid for Medicaid billing
  - Diagnosis codes will tell you which codes are good for billing
    - The diagnosis codes with the red arrow are not allowed by Medicaid.
    - In most cases the green arrows are accepted by Medicaid

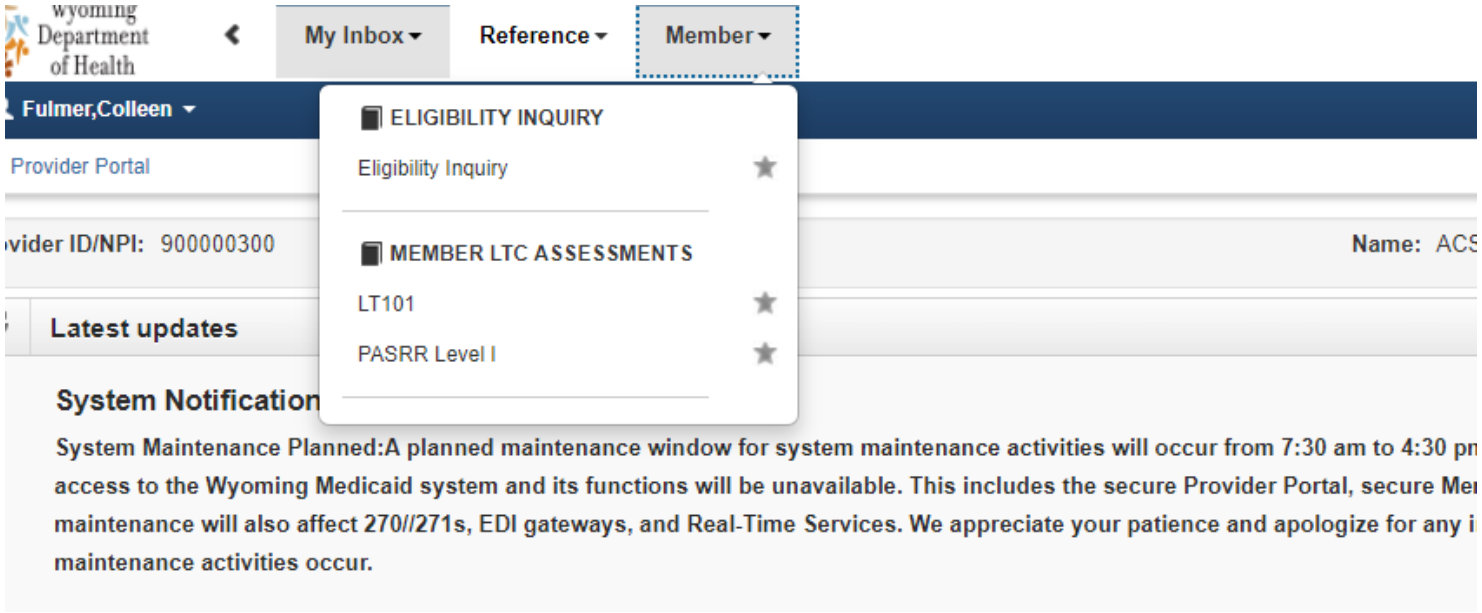
- Diagnosis codes are required for a PASRR I and II.

PASRR Level I- Sign in



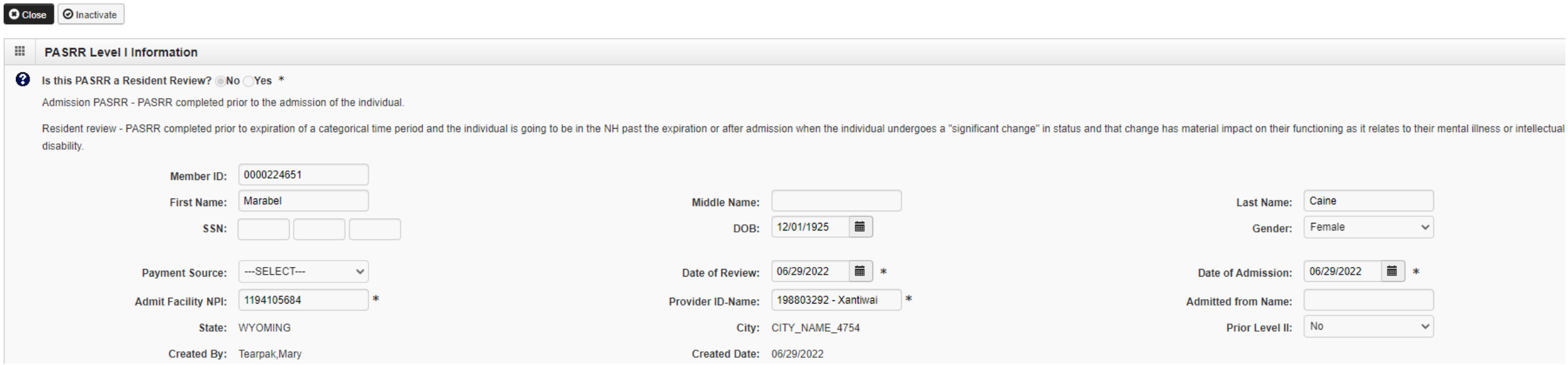
- Go to Wyoming Medicaid HomePage
- Select the appropriate domain (Provider ID)
- Select Eligibility Inquiry

PASRR Level I- Adding a PASRR Level I



- Select Member
- Select PASRR Level I
- Select “Add”

PASRR Level I- Resident Review

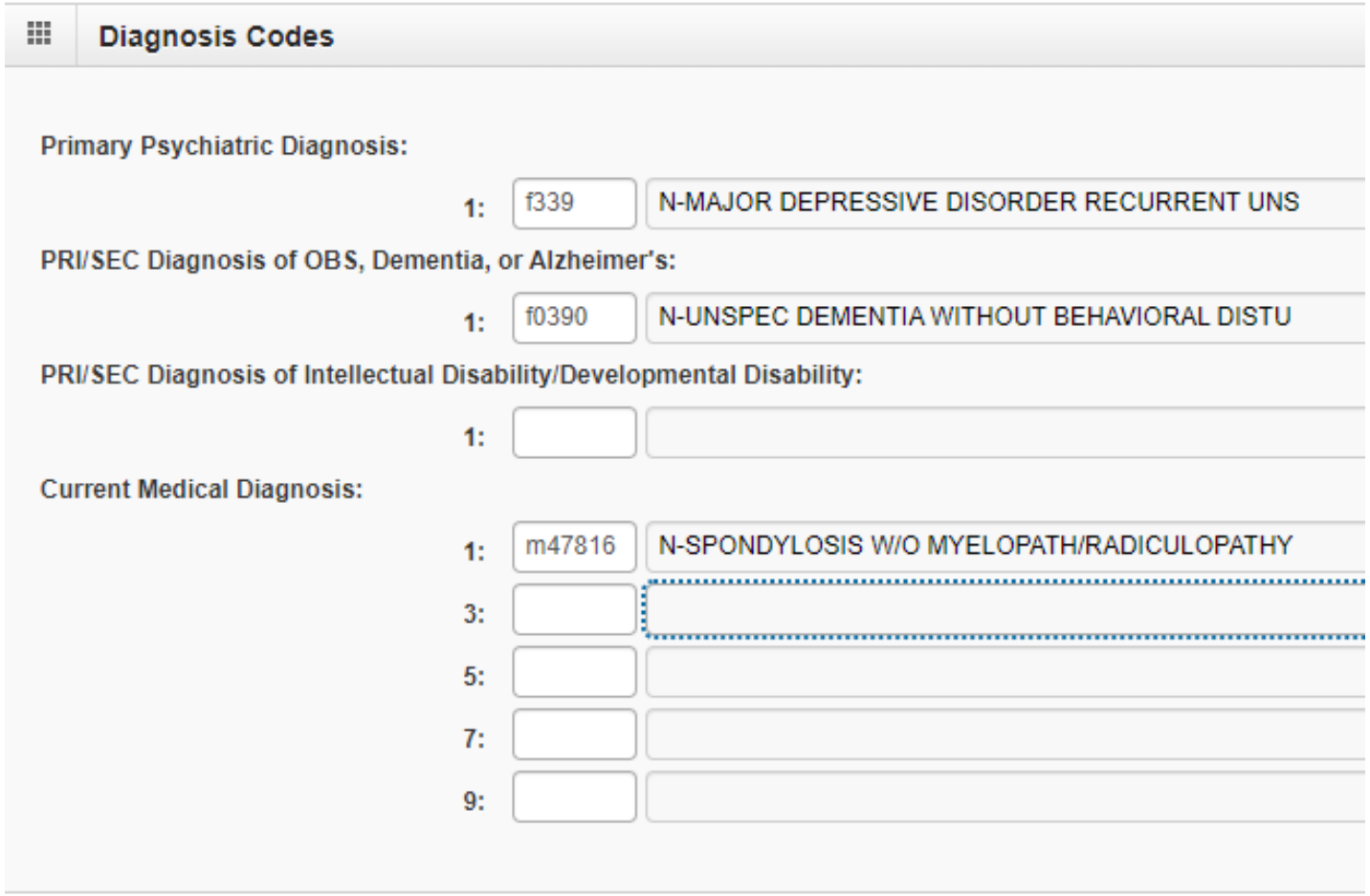


- Is this PASSR a resident review?
  - If yes, was there a significant change in condition?
  - If no, this is an admit PASRR II
- Enter all the member statistical data
- Enter the NPI of the provider
  - If correct the facility information will populate

PASRR Level I- Address for Non-Medicaid Members

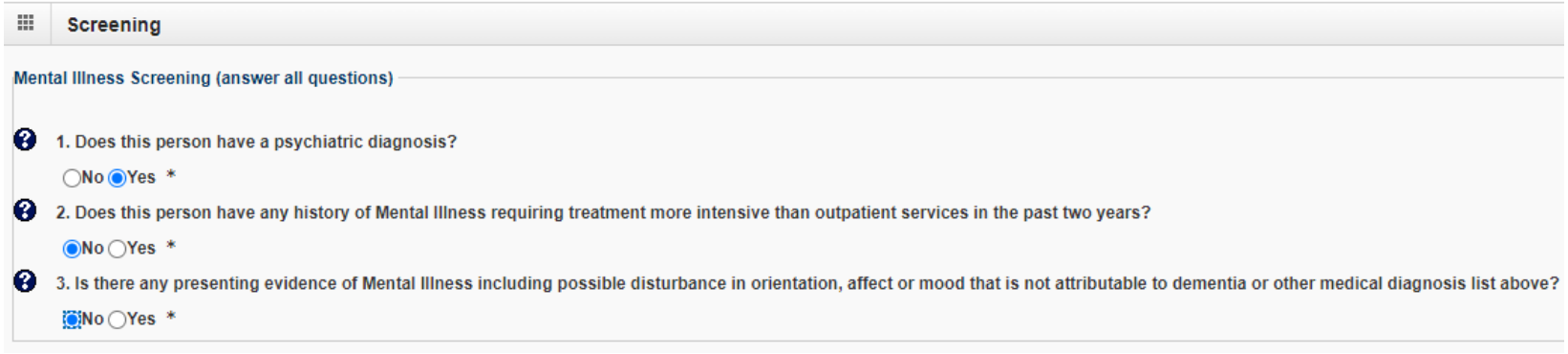
If the member is not Medicaid eligible at the time of the PASRR I, validate the members address

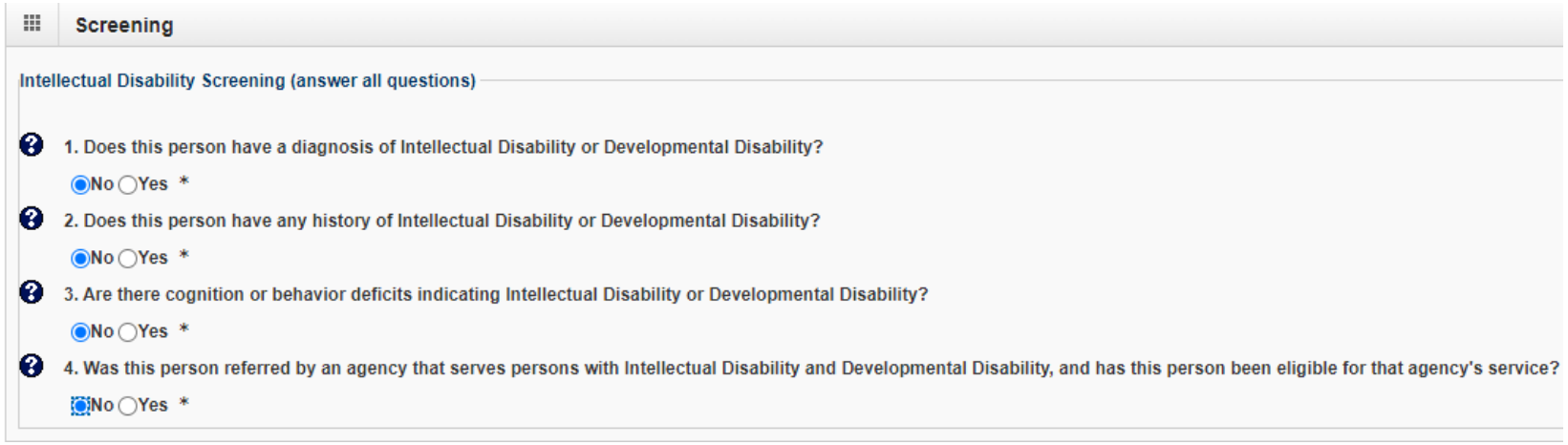
PASRR Level I- Diagnosis codes



- Enter the appropriate diagnosis codes.
  - All diagnosis codes must be entered with out the "." or decimal point
- If the diagnosis code does not populate a description, it is invalid.
  - Visit ICD10data.com for allowed diagnosis code(s)

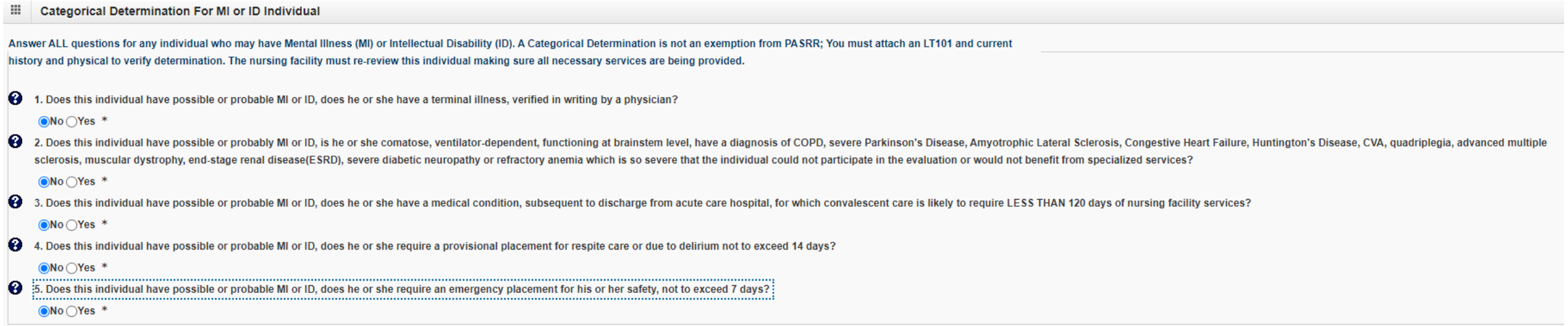
PASRR Level I- Screening Question





- Each question must be answered yes or no as applicable for the PASRR Level I
- This is resident specific

PASRR Level I- Categorical Determination



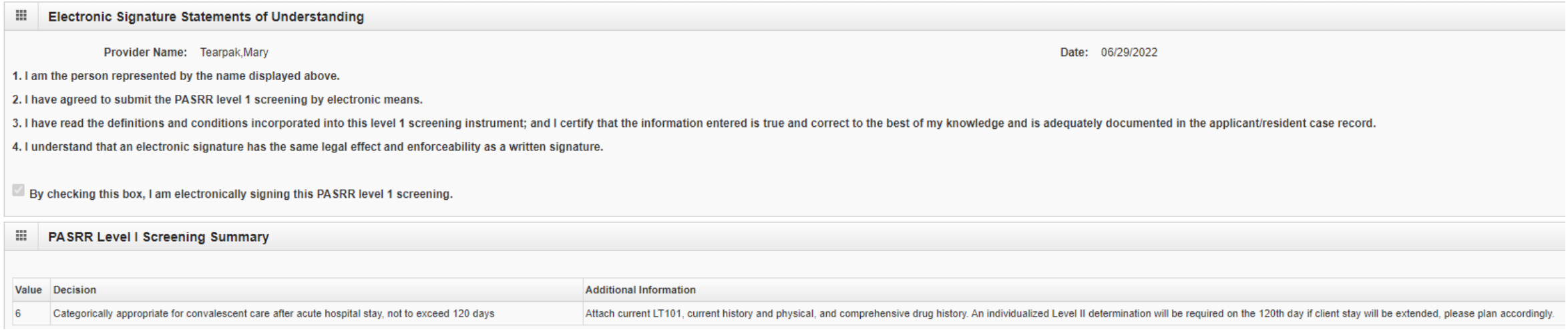
Categorical Determination For MI or ID Individual

Answer ALL questions for any individual who may have Mental Illness (MI) or Intellectual Disability (ID). A Categorical Determination is not an exemption from PASRR; You must attach an LT101 and current history and physical to verify determination. The nursing facility must re-review this individual making sure all necessary services are being provided.

1. Does this individual have possible or probable MI or ID, does he or she have a terminal illness, verified in writing by a physician?
   ◉No ○Yes *
2. Does this individual have possible or probably MI or ID, is he or she comatose, ventilator-dependent, functioning at brainstem level, have a diagnosis of COPD, severe Parkinson's Disease, Amyotrophic Lateral Sclerosis, Congestive Heart Failure, Huntington's Disease, CVA, quadriplegia, advanced multiple sclerosis, muscular dystrophy, end-stage renal disease(ESRD), severe diabetic neuropathy or refractory anemia which is so severe that the individual could not participate in the evaluation or would not benefit from specialized services?
   ◉No ○Yes *
3. Does this individual have possible or probable MI or ID, does he or she have a medical condition, subsequent to discharge from acute care hospital, for which convalescent care is likely to require LESS THAN 120 days of nursing facility services?
   ◉No ○Yes *
4. Does this individual have possible or probable MI or ID, does he or she require a provisional placement for respite care or due to delirium not to exceed 14 days?
   ◉No ○Yes *
5. Does this individual have possible or probable MI or ID, does he or she require an emergency placement for his or her safety, not to exceed 7 days?
   ◉No ○Yes *

- These questions will drive the need for a PASRR II and create the categorical determination for the PASRR Level I

PASRR Level I- Submission



Electronic Signature Statements of Understanding

Provider Name: Tearpak,Mary Date: 06/29/2022

1. I am the person represented by the name displayed above.
2. I have agreed to submit the PASRR level 1 screening by electronic means.
3. I have read the definitions and conditions incorporated into this level 1 screening instrument; and I certify that the information entered is true and correct to the best of my knowledge and is adequately documented in the applicant/resident case record.
4. I understand that an electronic signature has the same legal effect and enforceability as a written signature.

☑ By checking this box, I am electronically signing this PASRR level 1 screening.

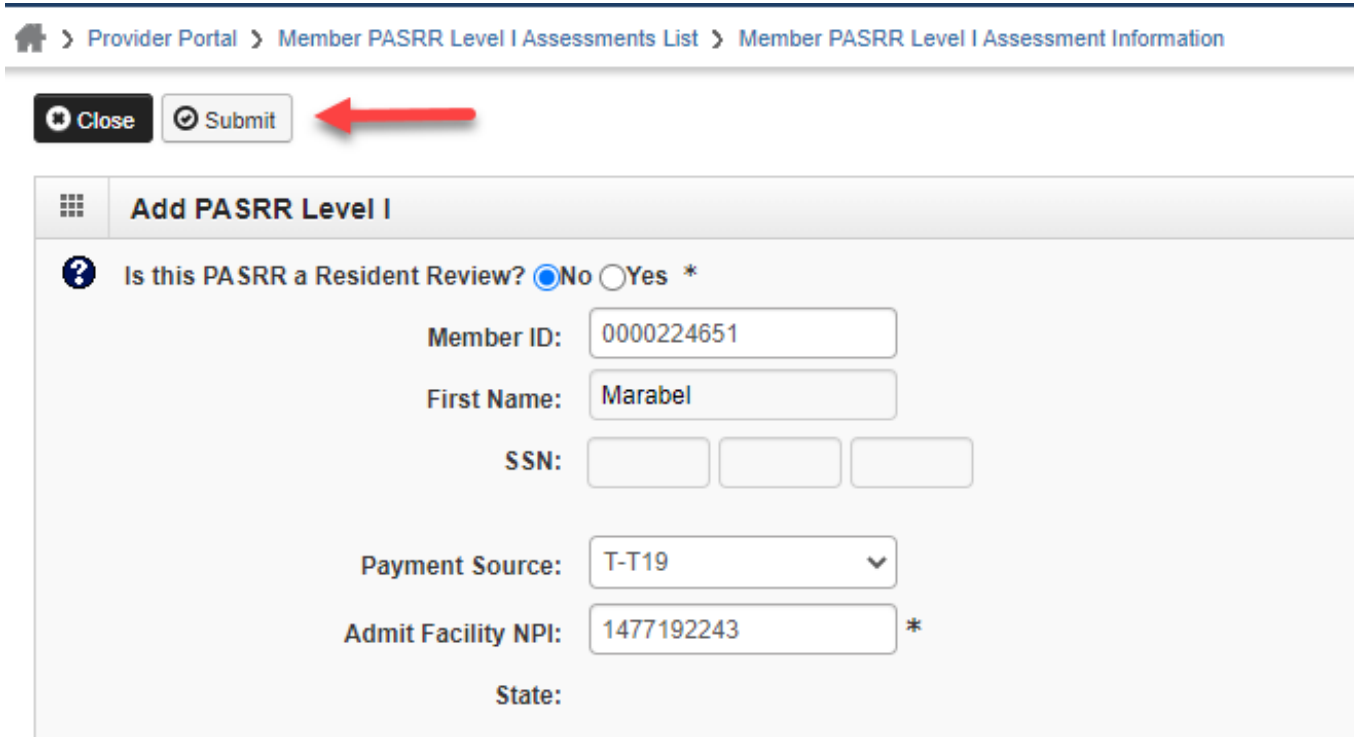
PASRR Level I Screening Summary

Value	Decision	Additional Information
6	Categorically appropriate for convalescent care after acute hospital stay, not to exceed 120 days	Attach current LT101, current history and physical, and comprehensive drug history. An individualized Level II determination will be required on the 120th day if client stay will be extended, please plan accordingly.

- After completing the PASRR Level I, select the small box and electronically sign the PASRR Level I

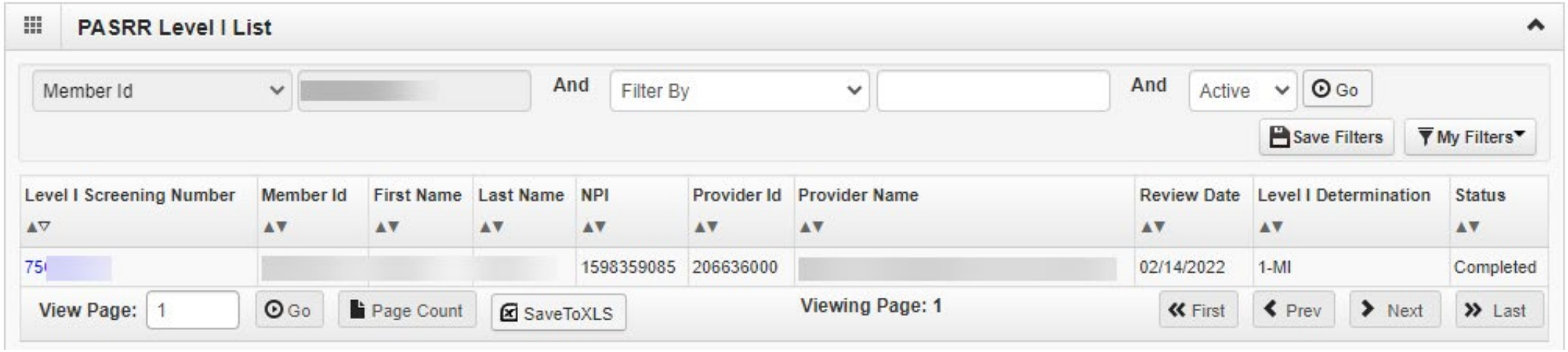
- The PASRR Level I screen summary indicates whether a PASRR II or categorical determination was made.

PASRR Level I- Submission



- When complete, click “Submit” at the top of the screen for submission
- This is retrievable from the PASSR list that members PASSRS are held in.

PASRR I- List



- If the PASRR Level I categorical determination is a 4-8 it is time sensitive.
  - A resident review and a full PASRR Level II must be completed prior to the end of the designated time

Value, Bill Type & Patient Status Codes

Value Codes 80 and 81- Requirement

- Previously Wyoming Medicaid policy required minimal use of value codes (80 and 81)
- The use of value codes, occurrence codes and occurrence span codes as appropriate are mandatory requirements as of January 01, 2022
- 80 – Covered days and member is in facility
- 81 – Non-Covered Days when the member is out of facility

Bill Type(s)

4	Type of Bill First Digit 1 Hospital 2 Skilled Nursing 3 Home Health 7 Clinic (ESRD,FQHC,RHC, IHS or CORF) 8 Special Facility (Hospital, CAH)	X	X	Enter the three (3) digit code indicating the specific type of bill. The code sequence is as follows:	
				Second Digit 1 Inpatient 2 ESRD 3 Outpatient 4 Other 5 Intermediate Care Level 1 6 Intermediate Care Level 2 7 Subacute Inpatient 8 Swing Bed Medicare/Medicaid	Third Digit 0 Non-payment/Zero Claim 1 Admit through discharge Claim 2 Interim – 1st Claim 3 Interim – Continuing claim 4 Interim – Last claim (thru Date is discharge date) 7 Adjustment or Replacement of a Prior Claim 8 Void of a Prior Claim

- Bill type should accurately reflect the patient status
- Example
  - Type of bill : 211
  - Patient status is: 30
  - Type of Bill is: Discharged
  - Patient Status is :Still a patient
  - The type of bill does not match patient status
    - Type of bill should be 212 or 213

Patient Status Codes

01	Discharged to home or self-care
02	Discharged/transferred to general hospital
03	Discharged/transferred to SNF
04	Discharged/transferred to an (ICF)
06	Discharged/transferred to home care
07	Left against medical advice
20	Expired
30	Still a patient

- Patient status must be on all claims
- There are other statuses, but these are the most common
- Patient status codes other than 30 (Still a patient) the BMS will automatically deduct one day

Value Code 80

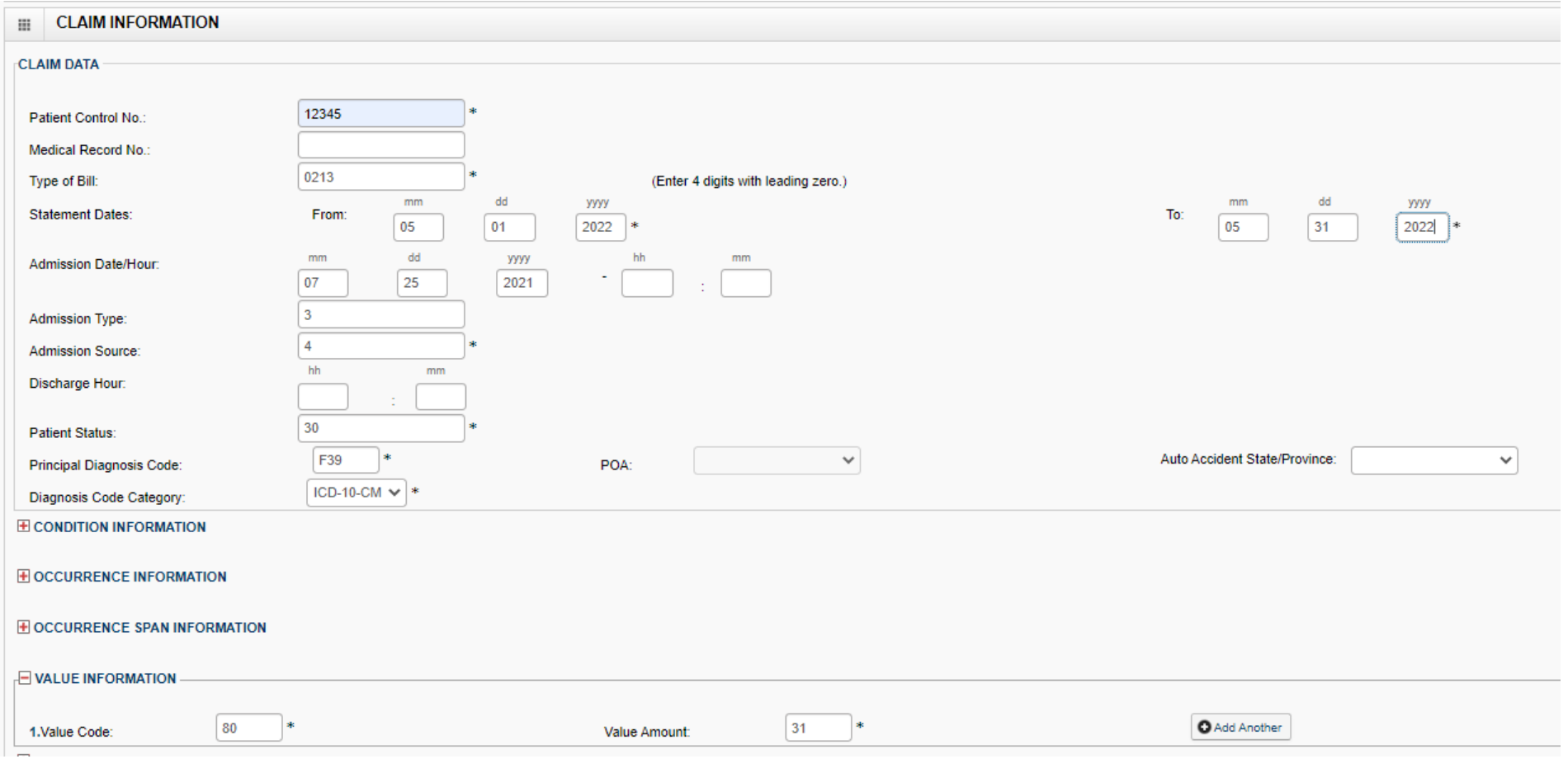
Medicaid Primary Billing Examples

Example 1- Value Code 80 Covered Days – Still a patient

- NH Claim – rev code 100
- TOB 21X
- Medicaid Only
- Admit date 07/25/221
- Still a patient
- Coverage dates 05/01/22-05/31/22

The first example is a straight Medicaid claim with no other insurance.

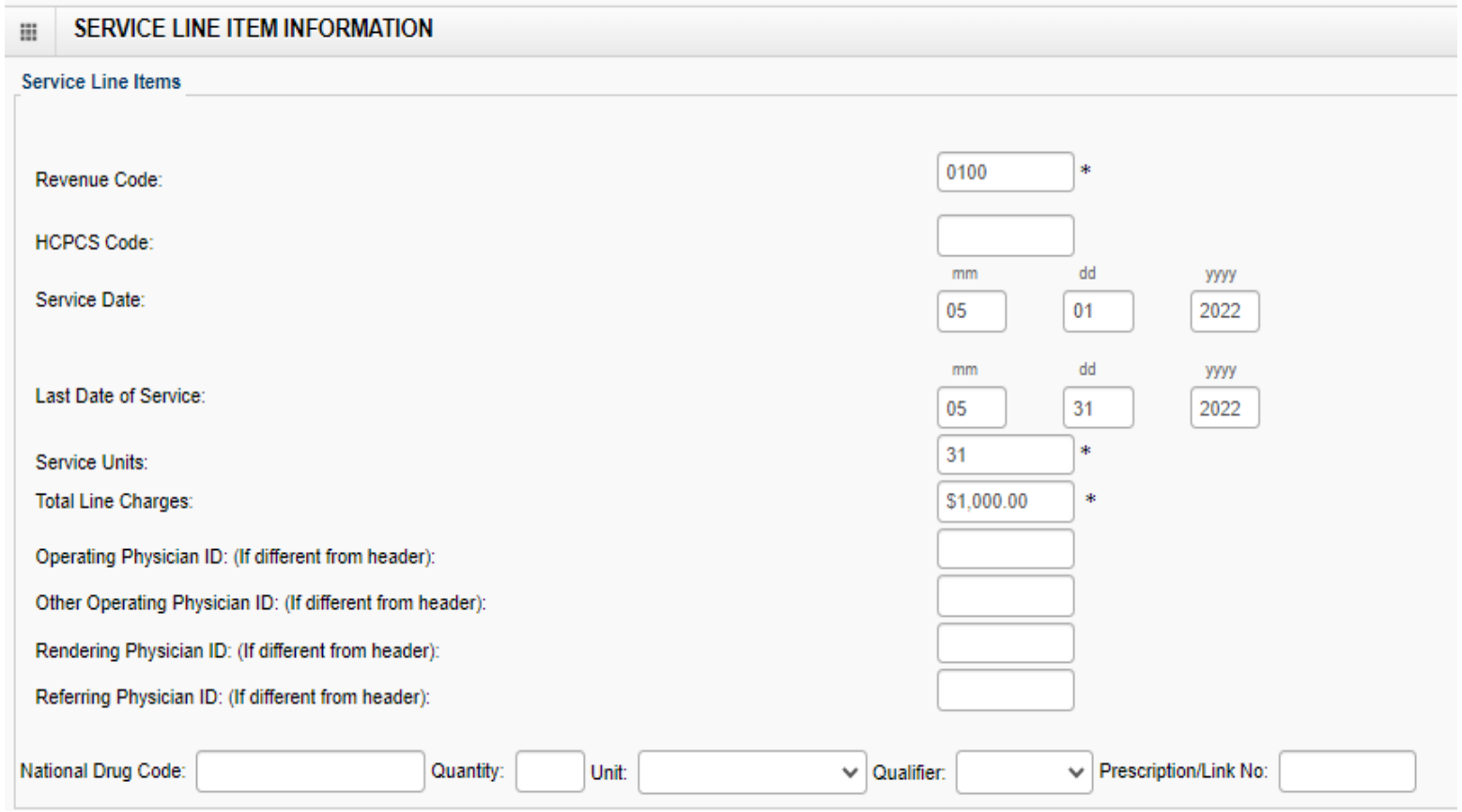
Example 1- Value Code 80 Covered Days



For Claim information:

- Asterisk indicates data is needed for the field
- The patient control number is the member ID number for the facility
- Value codes and Date of service must match

Example 1- Service Line Information



- Service date will match statement dates and Value Code 80
- Total line charges is your usual and customary charges
  - The cost of the facility doing business

Example 2- Value Code 80 – Date of Death

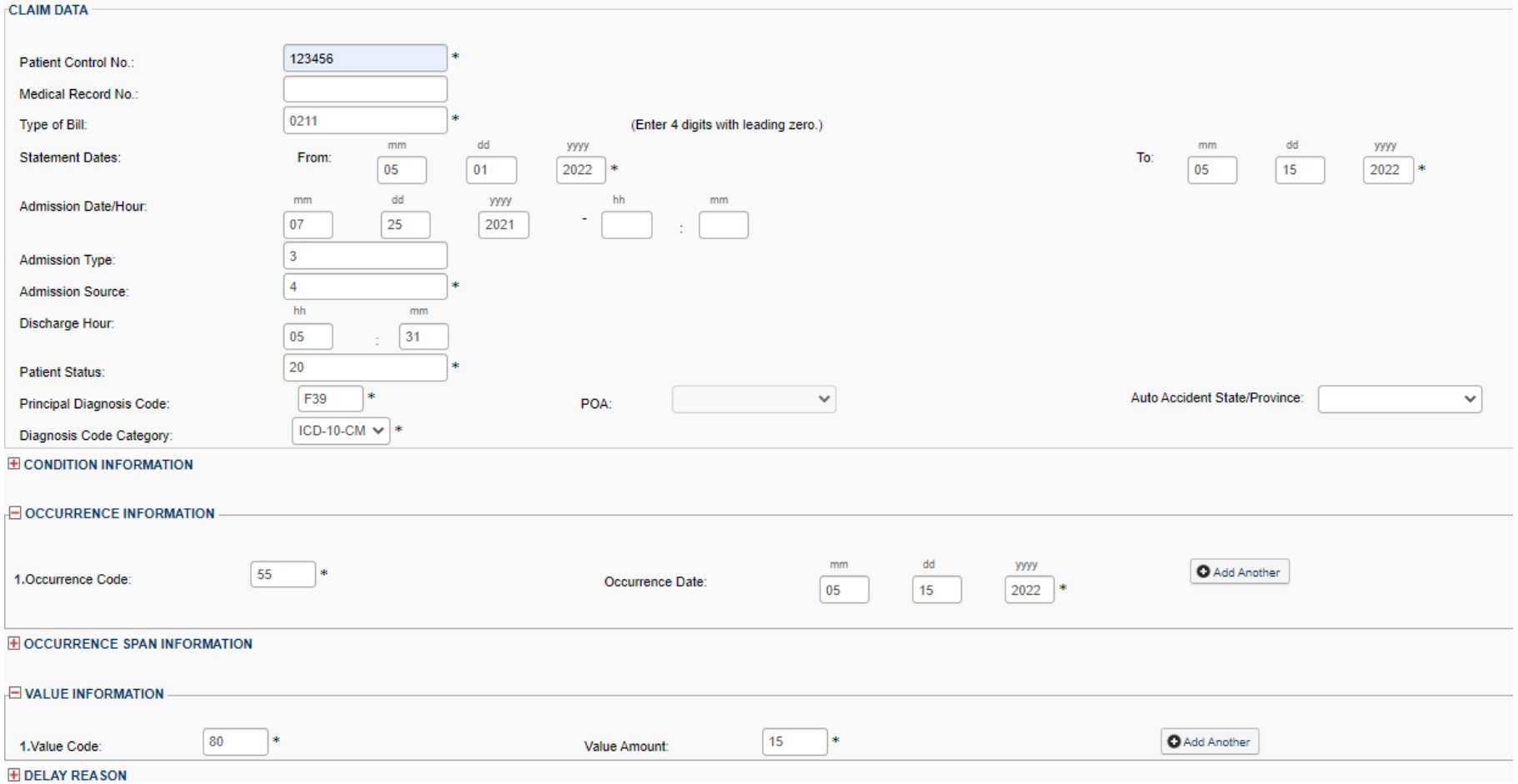
- NH Claim – rev code 100
- Type Of Bill 21X
- Medicaid Only
- Admit date 07/25/221
- Date of Death 05/15/2022
- Coverage dates 05/01/22-05/15/22

This is for a straight Medicaid claim with Date of Death.

Medicaid does not reimburse for the date of death.

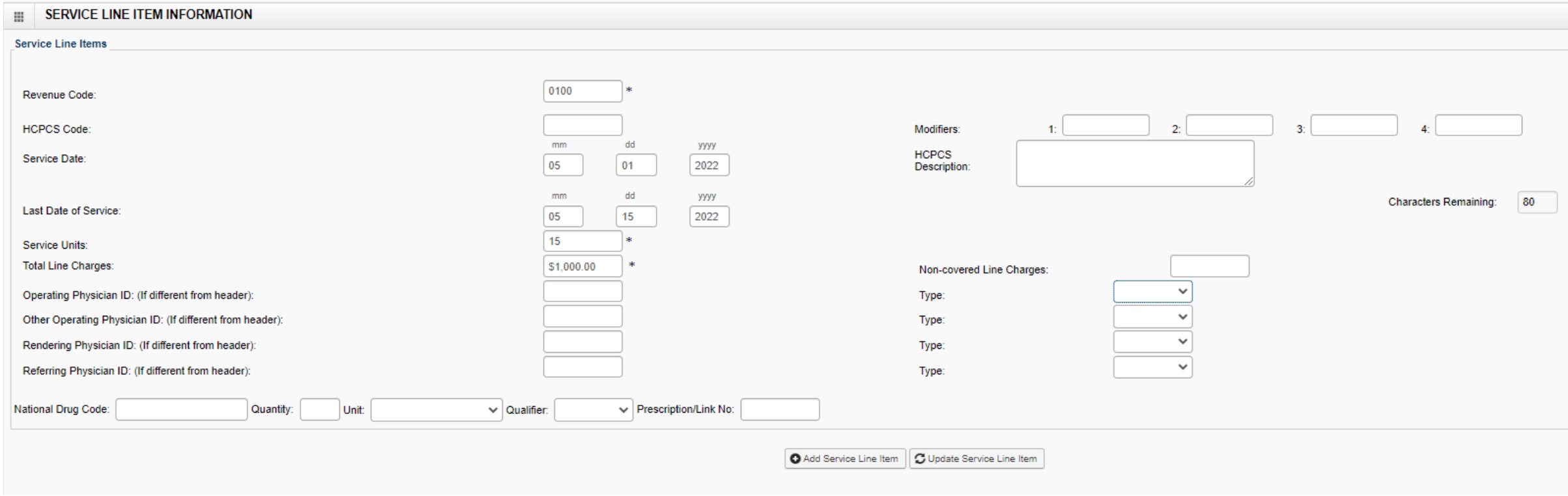
The BMS automatically deducts 1 day from dates of service billed.

Example 2- Value Code 80 – Date of Death



- Value code 80 is for the full 15
  - The Date of Death
  - Date of Death is May 15th

Examples 2- Value Code 80 – Date of Death



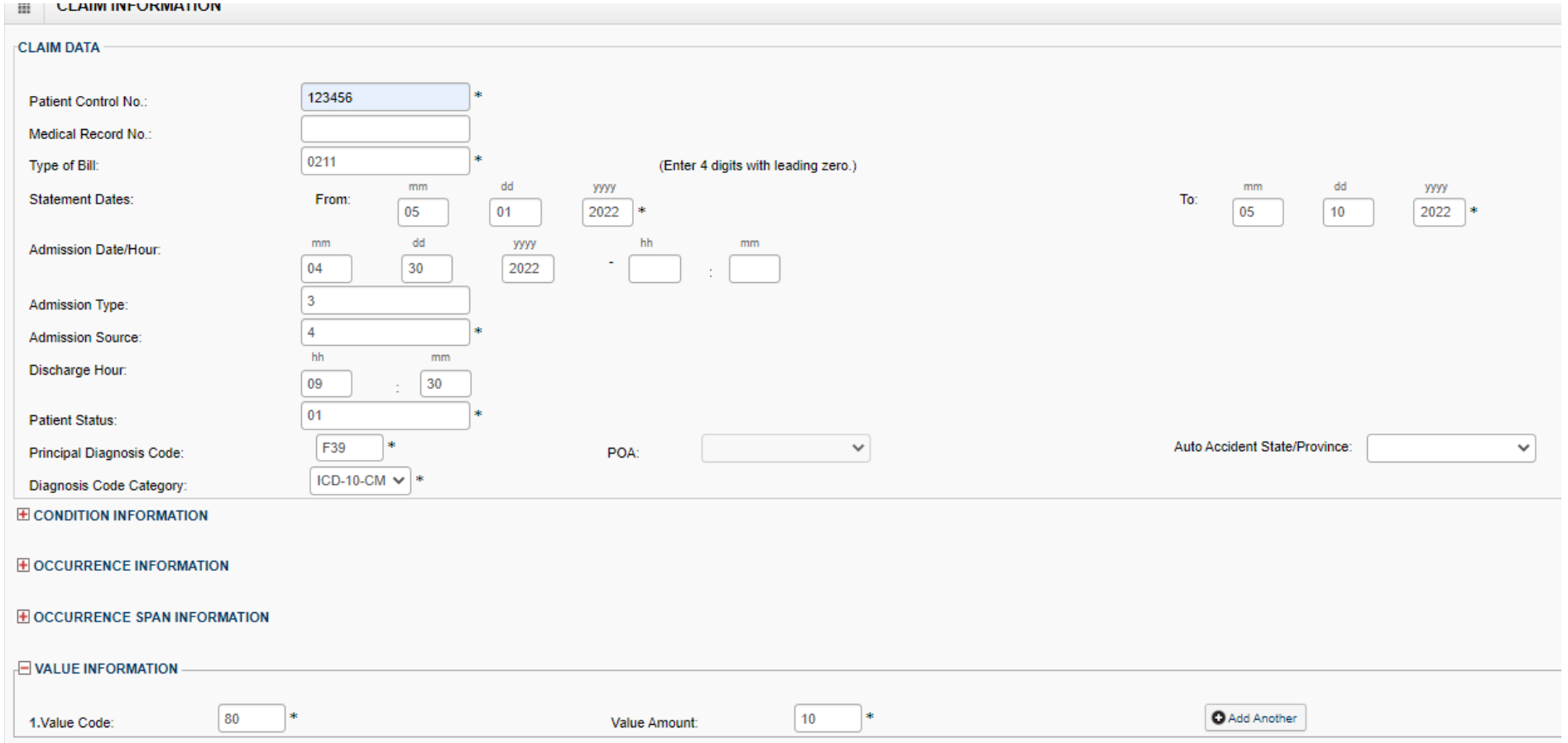
- Bill all days through the Date of Death
- Medicaid will not pay for Date of Death
- The provider portal will account for this and adjust accordingly

Example 3- Value Code 80 – Date of Discharge

- NH Claim – rev code 0100
- TOB 21X
- Medicaid Only
- Admit date 07/25/221
- Date of Discharge 05/10/2022
- Coverage dates 05/01/22-05/10/22

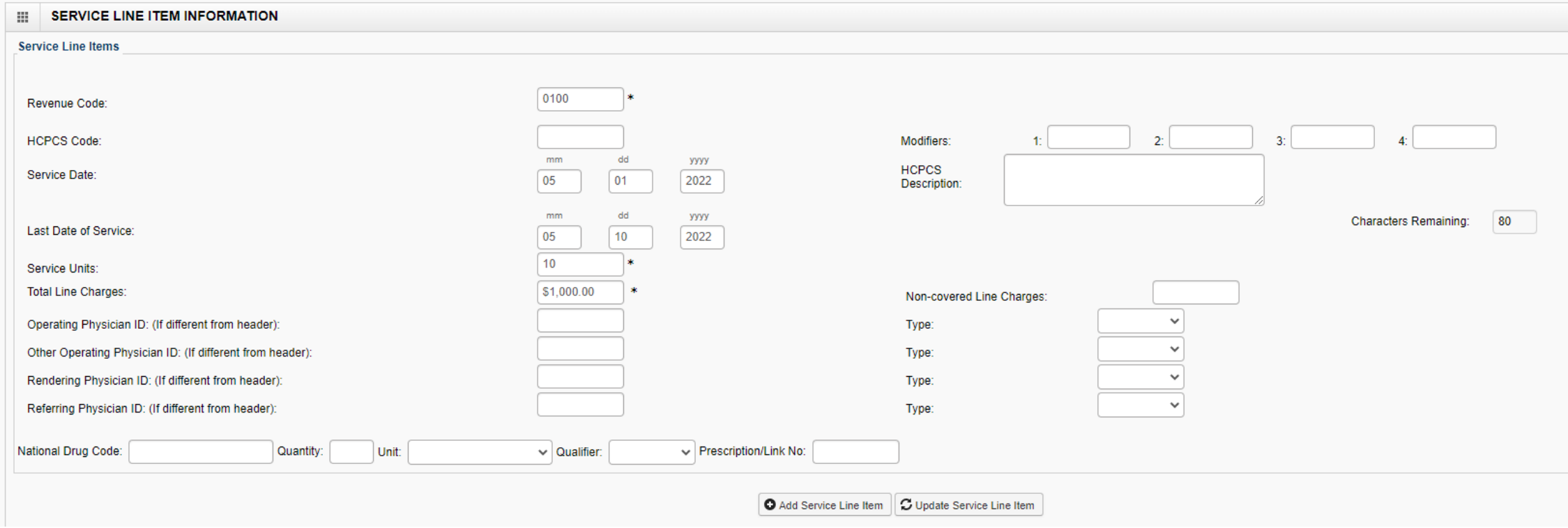
This is a straight Medicaid claim with a Date of Discharge

Example 3 – Value Code 80 – Date of Discharge



- Value code 80 is for the full 10 days as the BMS will deduct the Date of Discharge
  - The member was a resident 10 days including date of discharge,

Example 3- Value Code 80 – Date of Discharge



- Bill all days through the Date of Discharge
- Medicaid will not pay for Date of Discharge,
- The provider portal will account for this and adjust accordingly

Value Codes 80 and 81

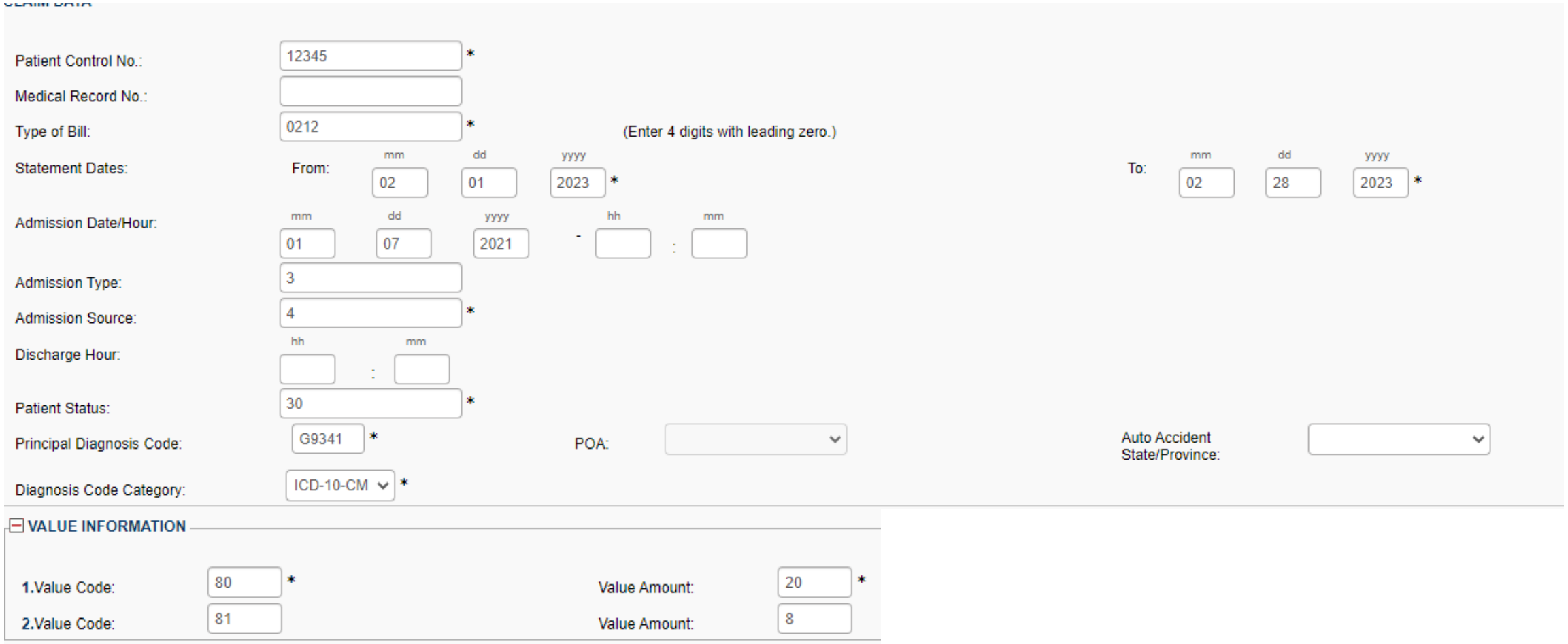
Medicaid Primary Billing Examples

Example 1- Value Codes 80 and 81

- NH Claim – rev code 0100
- TOB 21X
- Medicaid Only
- Admit date 07/25/2021
- Leave Dates: 08/03/2021-08/07/2022
- Coverage dates 08/01/2021-08/31/2021

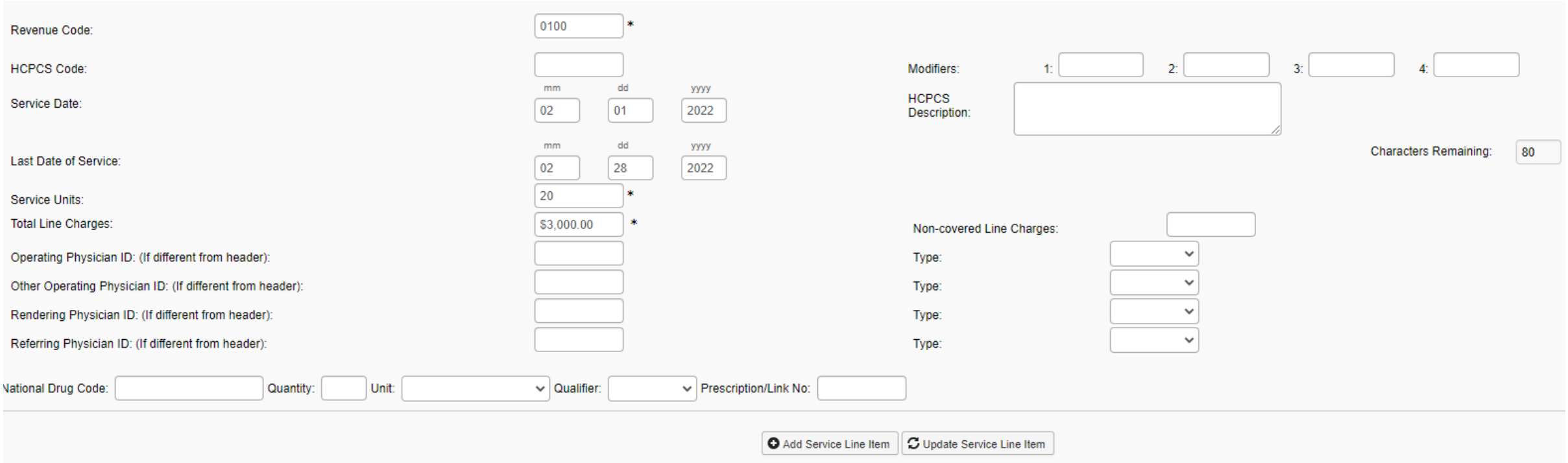
This will be a straight Medicaid claim no other insurance, but leave dates for the member

Examples 1- Value Codes 80 and 81



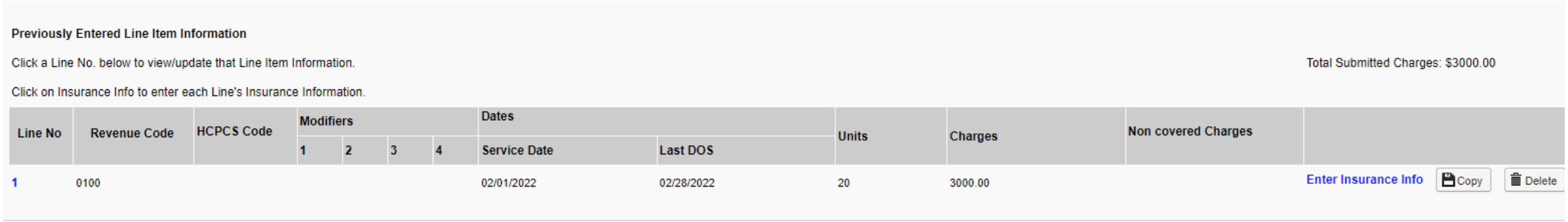
- Value codes 80 and 81 must equal the days billed

Example 1- Value Codes 80 and 81



- Revenue Code 0100 signifies Room and Board days
- Total days are billed
- Claims that do not have a leave of absence bill the full date range
    - Example 08/01-08/31 vs 08/01-08/01

Example 1- Value Codes 80 and 81



Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.

Total Submitted Charges: $3000.00

Click on Insurance Info to enter each Line's Insurance Information.

Line No	Revenue Code	HCPCS Code	Modifiers				Dates		Units	Charges	Non covered Charges	
			1	2	3	4	Service Date	Last DOS				
1	0100						02/01/2022	02/28/2022	20	3000.00		Enter Insurance Info Copy Delete

- Value code 80 equals 20
- Value code 81 equals 8
- Total charges is shown in the right-hand corner for $3000.00

Value Code 80, 81 and 82

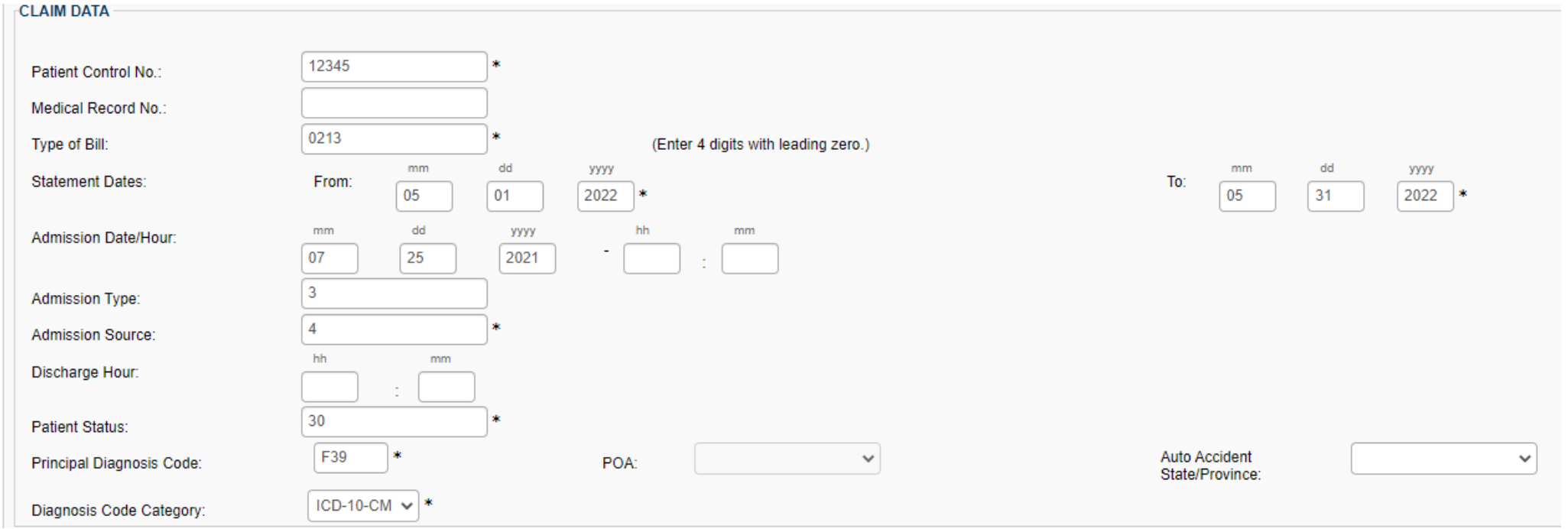
Medicare Billing Examples

Example 1- Value code 80, 81 and 82

- NH Claim –Rev Code 0100
- TOB 21X
- Medicaid and Medicare
- Admit date 04/01/2022
- Medicare covered dates = 10
- Coverage dates 05/01/22-05/21/22

This will be an example of Medicare billing with Medicaid

Example 1- Value code 80 and 82


CLAIM DATA

Patient Control No.: 12345 *

Medical Record No.:

Type of Bill: 0213 * (Enter 4 digits with leading zero.)

Statement Dates: From: mm 05 dd 01 yyyy 2022 * To: mm 05 dd 31 yyyy 2022 *

Admission Date/Hour: mm 07 dd 25 yyyy 2021 - hh : mm

Admission Type: 3

Admission Source: 4 *

Discharge Hour: hh : mm

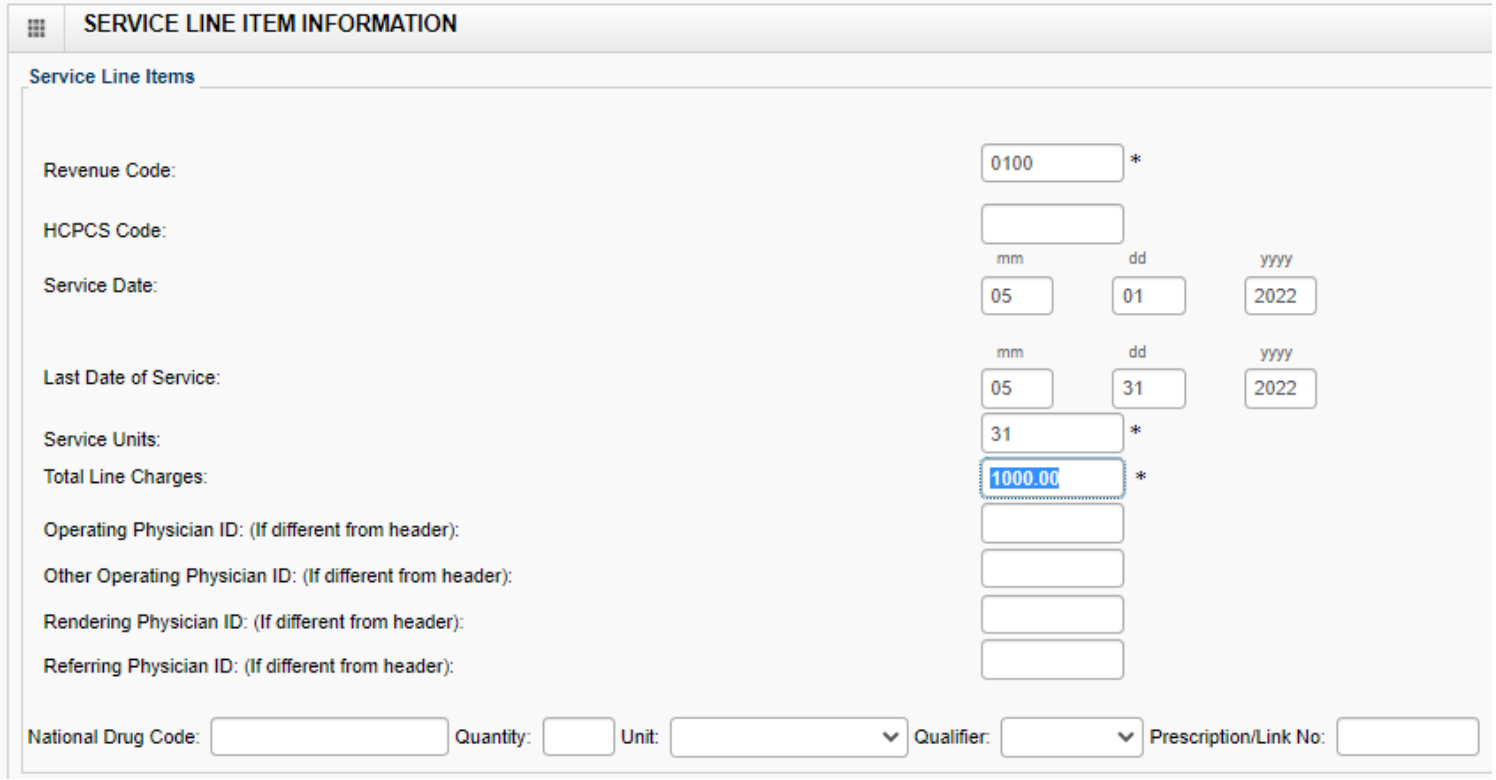
Patient Status: 30 *

Principal Diagnosis Code: F39 * POA: Auto Accident State/Province:

Diagnosis Code Category: ICD-10-CM *

- When billing Medicare bill the therapy (ancillary) codes as appropriate
- Therapy codes are included in the Nursing Home per diem for
  - Medicare will pay therapy charges
  - If billed on an OPPS/Professional claim, therapy codes will deny, and show as a denial on the RA

Example 1- Value code 80 and 82



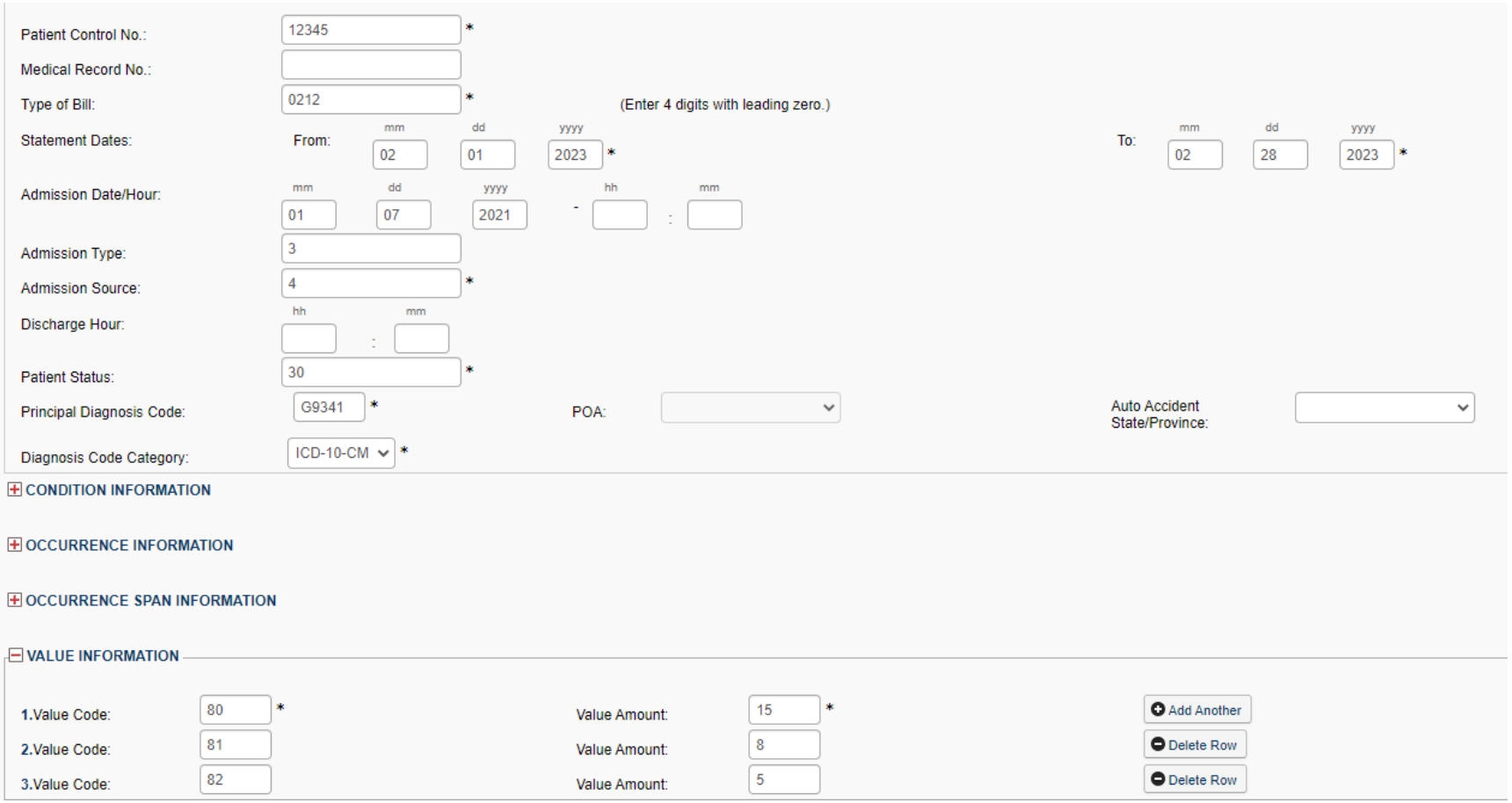
- When billing Medicare bill the therapy (ancillary) codes as appropriate
- Therapy codes are included in the Nursing Home per diem for
  - Medicare will pay therapy charges
  - If billed on an OPPS/Professional claim, therapy codes will deny, and show as a denial on the RA

Example 2- Value codes 80, 81 and 82

- NH Claim – Rev Code 0100
- TOB 21X
- Medicaid and Medicare
- Admit date 04/01/2022
- Medicare covered dates = 10
- Leave days- 05/05/22-05/10/22
- Coverage dates 05/01/22-05/31/22

This will be an example of Medicare billing with leave days

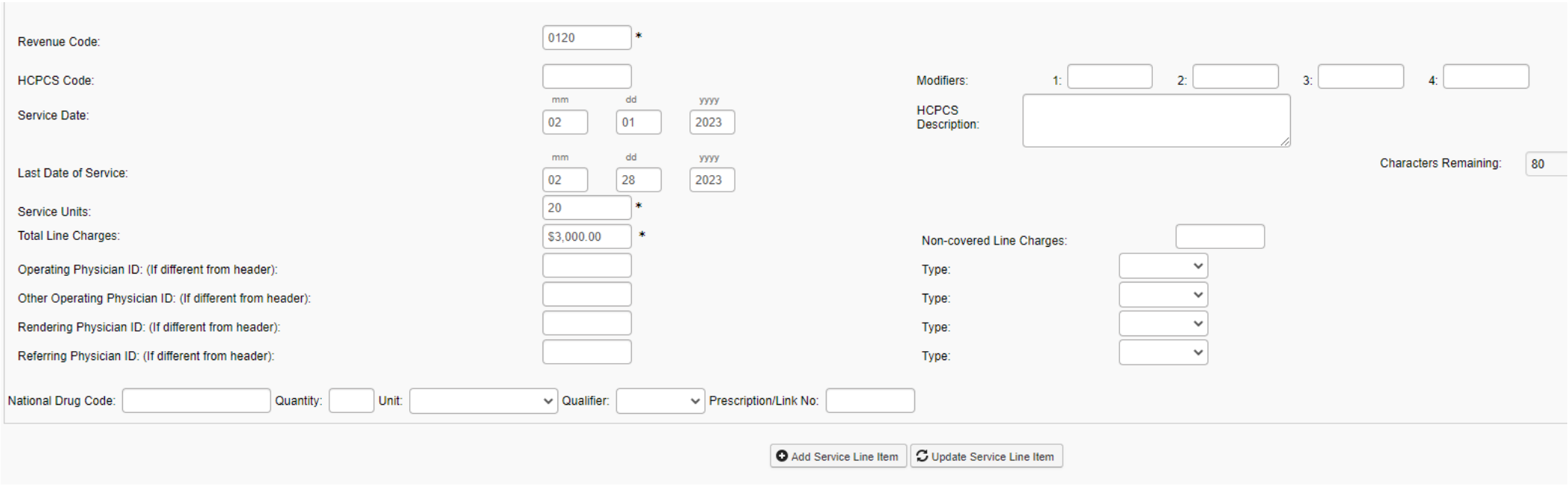
Example 2- Value codes 80, 81 and 82



There are three value codes that Need to be billed

- 80- Covered days
- 81- Leave days
- 82 Medicare Coinsurance days

Example 2- Value codes 80, 81 and 82



- This line is your room and board revenue code 0120 (only if billing Medicare!)
- The total in Value code 80 is 15 days covered, and the 10 days of Medicare Covered value code 81, plus the 5 days of leave with value code 82
- This equals 28 days billed

Top 4 Claim Denials with Resolution

Edits, CARC, RARC and Resolution

Top 4 Denials - Section Review

In this section we will discuss:

- Top 4 denial reasons on Nursing Home claims
- CARC and RARC
- Medicaid Edits and descriptions
- Resolution

Top Denial-Error Code 7059

Top Denial

- Error Code 7059: Admission claim not on file
- CARC 16
  - Claim service lacks information
- RARC N221
  - Missing Admitting History and Physical Report

- Verify the admit date on the claim to NF records
  - If incorrect resubmit with correct date
  - If correct ask the following questions:
    - Who paid the admit claim?
      - If not, Medicaid complete an attestation form.
      - If Medicaid paid verify the dates match billed vs attestation
    - Is there an attestation on file with the admit date on the claim?
      - If no, complete the form, allow time to be added, then rebill with the correct admit date

Third Top Denial-Error Code 1225

- Error Code-1225
- CARC 18
  - Exact duplicate of claim
- RARC N522
  - Duplicate of claim processed

- Void or adjust the paid claim in history if the claim did not pay correctly
  - If a void is completed, rebill the claim for payment
  - If completing a void, billing before the next billing cycle will help negate confusion on payment vs take back credits on the RA

Second Top Denial- Error Code-7053

- Error Code- 7053 Invalid Rev code at the line
- This will post when these codes are wrapped into the nursing home per diem
- CARC 16
  - Claim lack information or has submission billing errors
- RARC M50
  - Missing Incomplete/invalid revenue codes

- The following revenue codes will deny:
  - 0022, 0183, 0250,0421,0431,0441,0500
    - These are ancillary codes and paid in the Nursing Home per diem
    - These codes are paid by Medicare
  - Bill as appropriate for Medicare, but expect denials on these codes
    - Revenue Code 0120 should pay, but will be at $0.00
    - Medicare typically pays more than Medicaid on Nursing Home Cross over claims

Fourth Top Denial- Error Code 1110

5th most common Denial:

- Diagnosis code not active
- CARC 167
    - This diagnosis code is not covered
- No RARC

- Is your diagnosis code active after searching?
    - If the diagnosis codes isn't valid, find an equitable diagnosis and rebill claim
    - If the diagnosis code is valid, reach out to provider services. 1-866-996-6223 or wyprovideroutreach@cns-inc.com

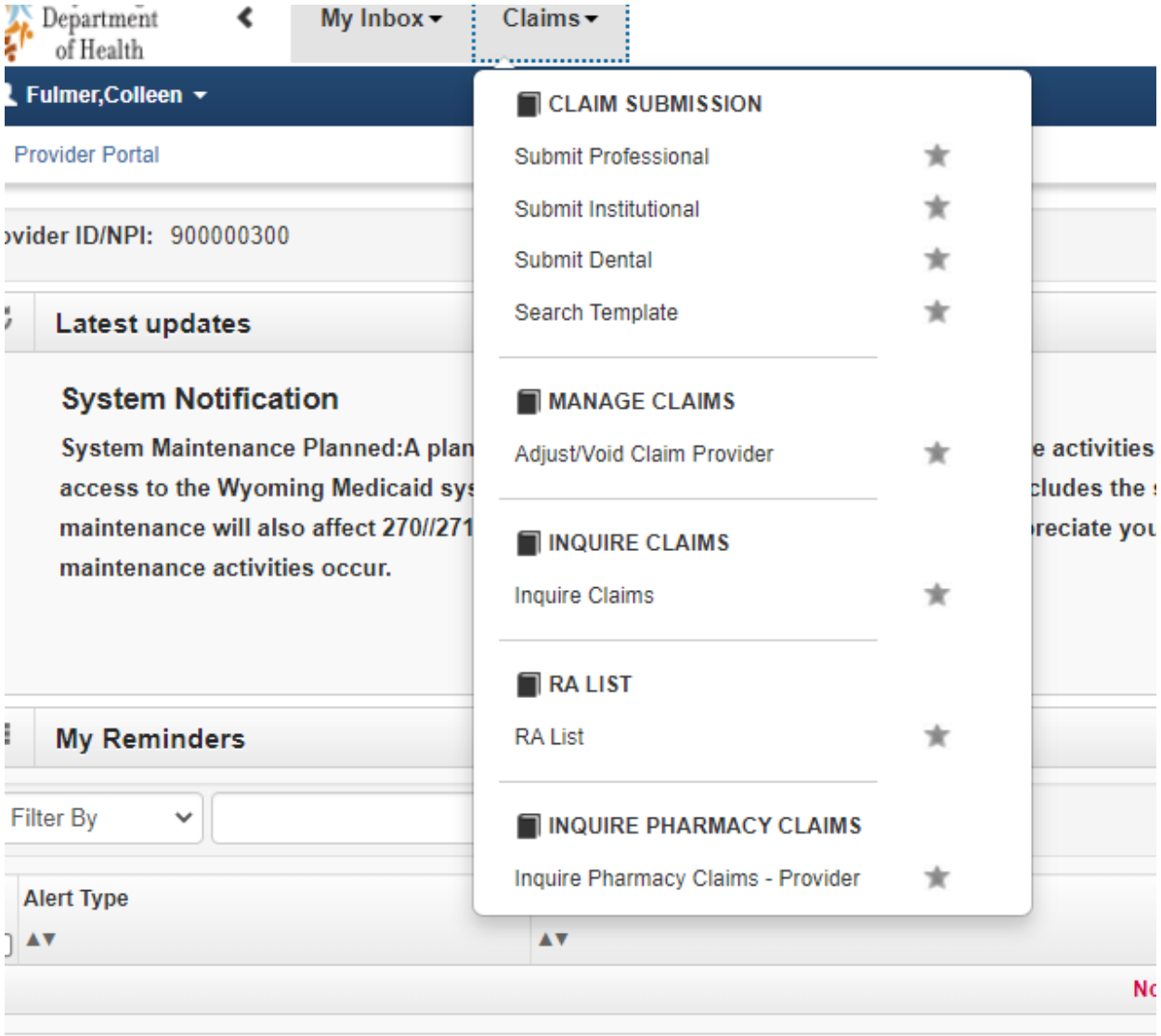
Nursing Home Claim Submission

Straight Medicaid with no TPL

Claim Submission-Signing on

- After sign on:
  - Select your Domain
  - Select claims access
  - Click GO

Claims Submission- Selecting Claim

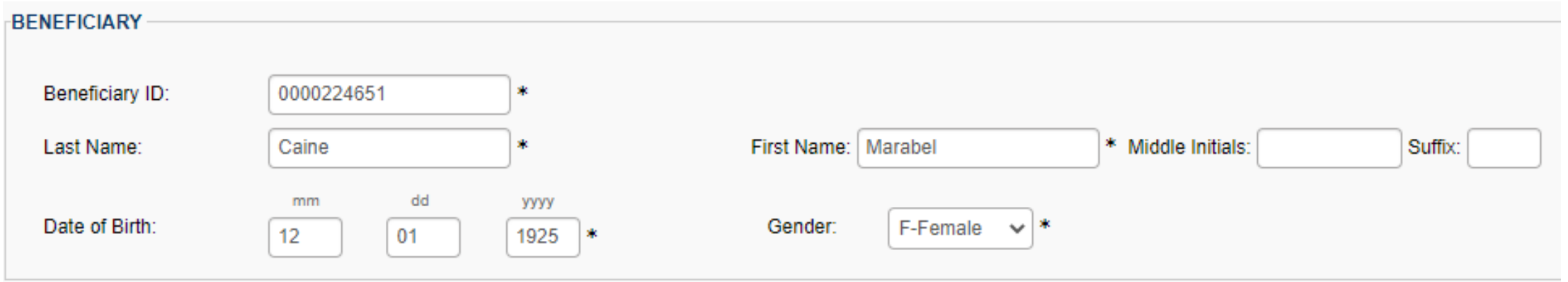


- Go to claims
- Submit Institutional

Claim Submission- Provider Information

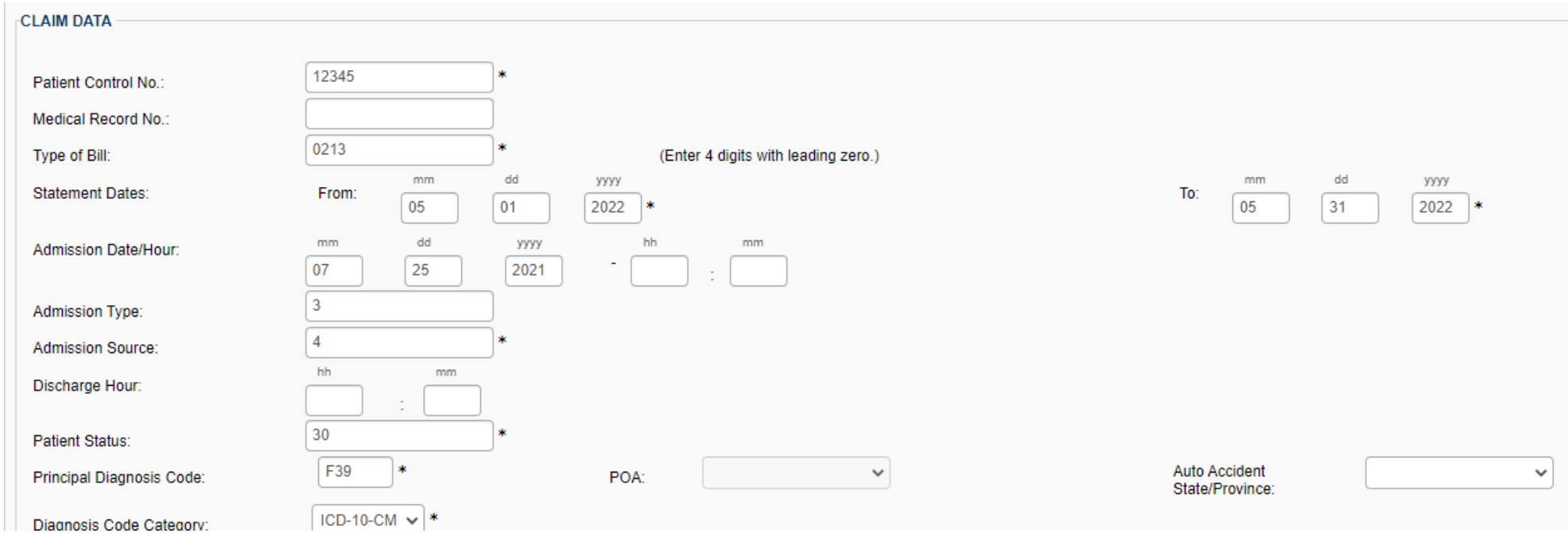
- Basic claim info:
  - Enter the taxonomy code, all capital letters must be used on taxonomies
  - Enter the Attending Provider Information
    - The taxonomy for the attending provider is required for a one-to-one match

Claim Submission- Beneficiary Information



- Enter the Beneficiary ID
- All other statistical data will populate when the Medicaid number is valid.

Claim Information

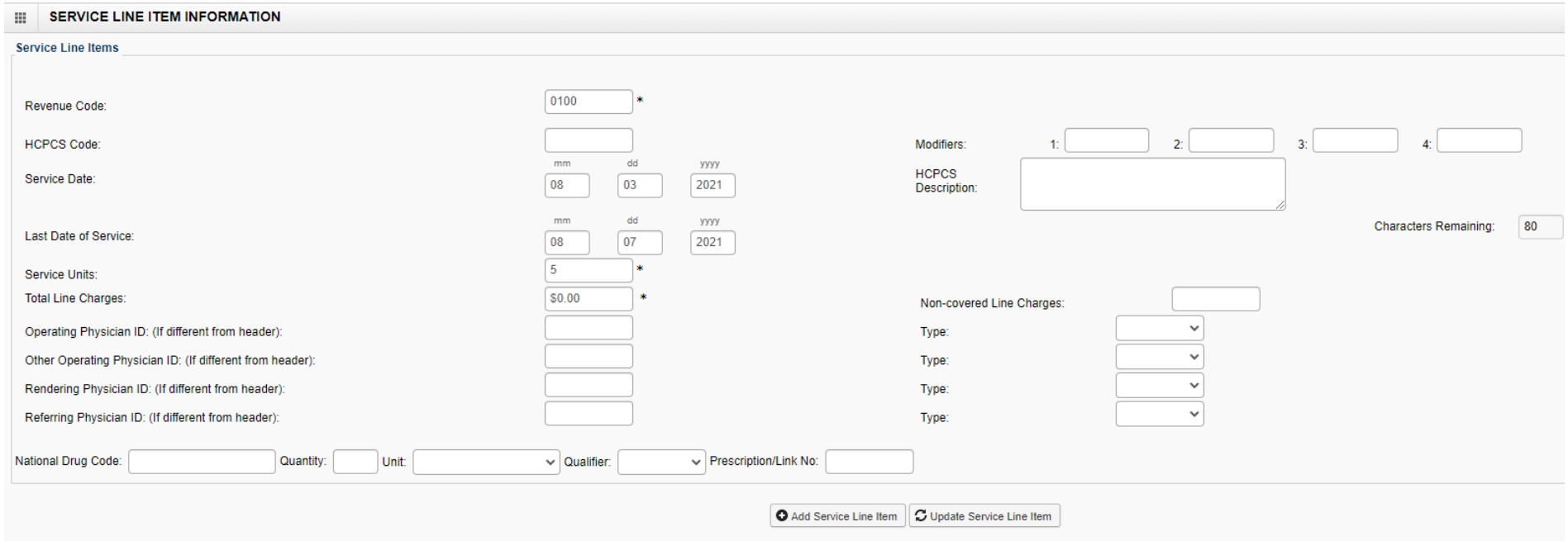


- Patient control number is the facility ID for the member
- To and from date will be the span date for services
- Admission date must match attestation if one is on file

Claim Information

- Value codes 80/81 must be used in billing
  - Value Code 81 is only required when there is a leave of absence
- Value codes help identify time spans and the location of the member, which is a factor in payment

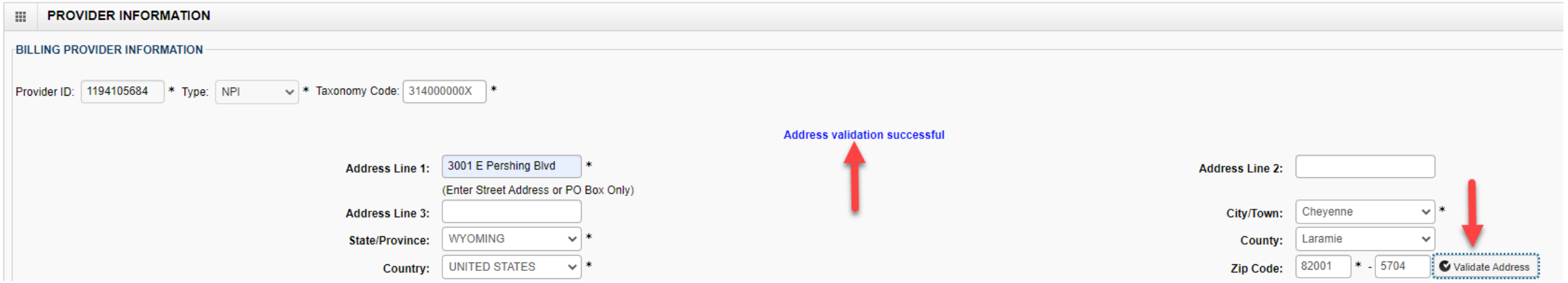
Claim Submission-Service Line-Item Information



- Enter required information for claim submission. Revenue code for Room and Board is required
  - Enter only one line of room and board
  - Revenue Code 0100 for Medicaid
  - Revenue Code 0120 for Medicare claims

- Add Service Line Item

Claim Submission- Address Validation



- When date entry is complete validate address and click “Submit Claim” at the top of the screen
- An additional box will pop up, if pop up blocker allows, with claim information and option to attach documentation

Reading Error Codes

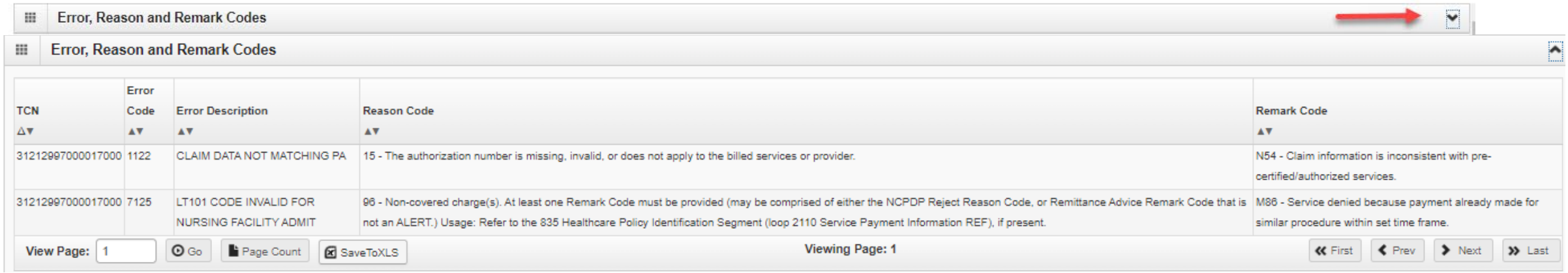
Error Codes on Claims

Reading Error Code- Choosing the claim

	TCN	From Date	To Date	Submitted Charges	Claim Status
☐	31212997000035000	08/21/2021	08/31/2021	$3,955.71	Denied
☐	32126000089000001	08/01/2021	08/31/2021	$8,362.87	Denied
☐	31212997000017000	08/11/2021	08/20/2021	$3,596.10	Denied

- Find the claim in question by doing a claims inquiry
- Click the blue hyper link to open the claim
- A quick reference guide can be found on the Wyoming Medicaid web page listed as
  - Claim Inquiry with Error Reason and Remark Codes

Reading Error Code- Error code display

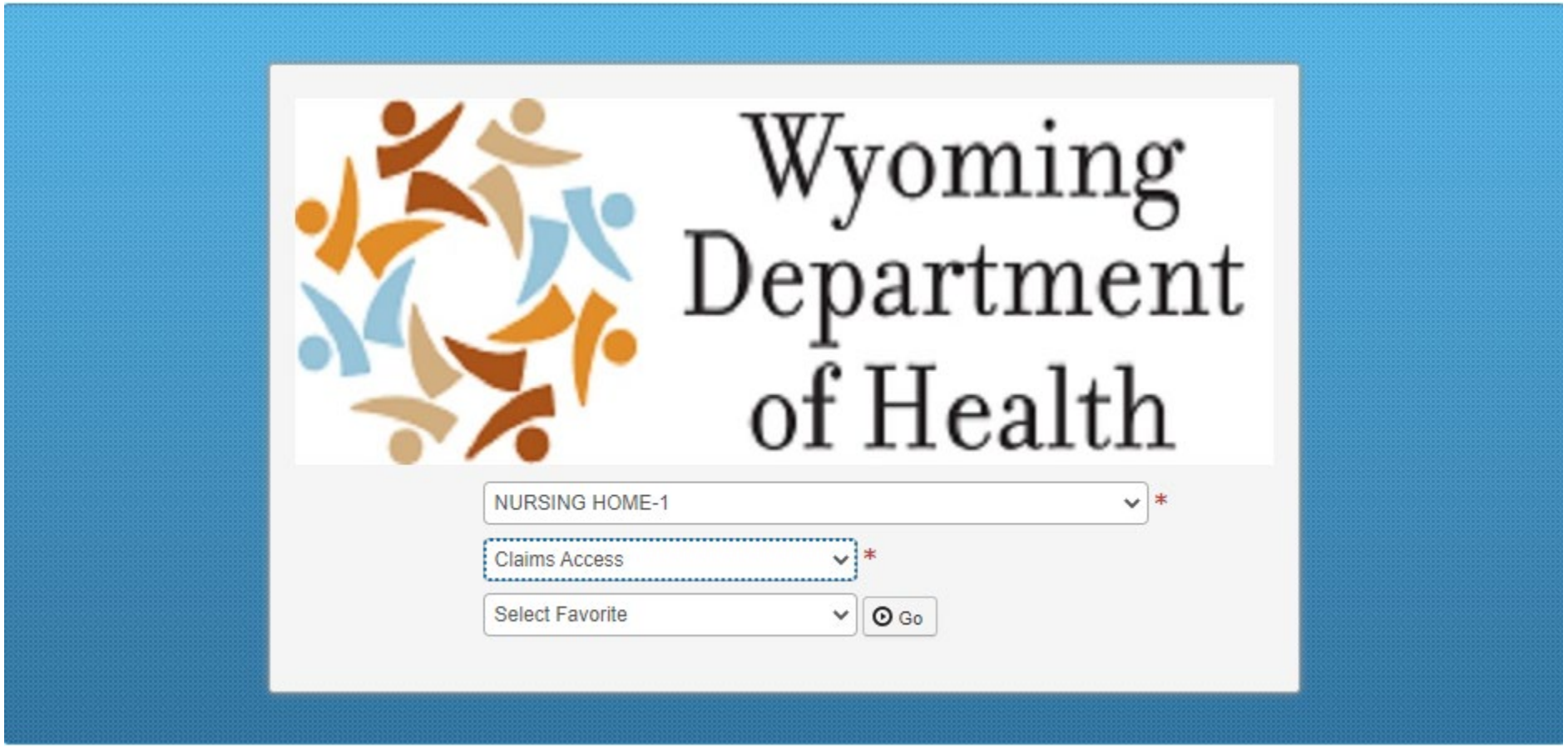


- Click the down arrow at the top of the screen
- This will populate the error codes for claim trouble shooting
  - Paid, Denied and Pay and Report code will show
  - Suspended codes will not
- CARC and RARC will still show
- These codes will appear on the corresponding RA (Remittance Advice)

Adjustments

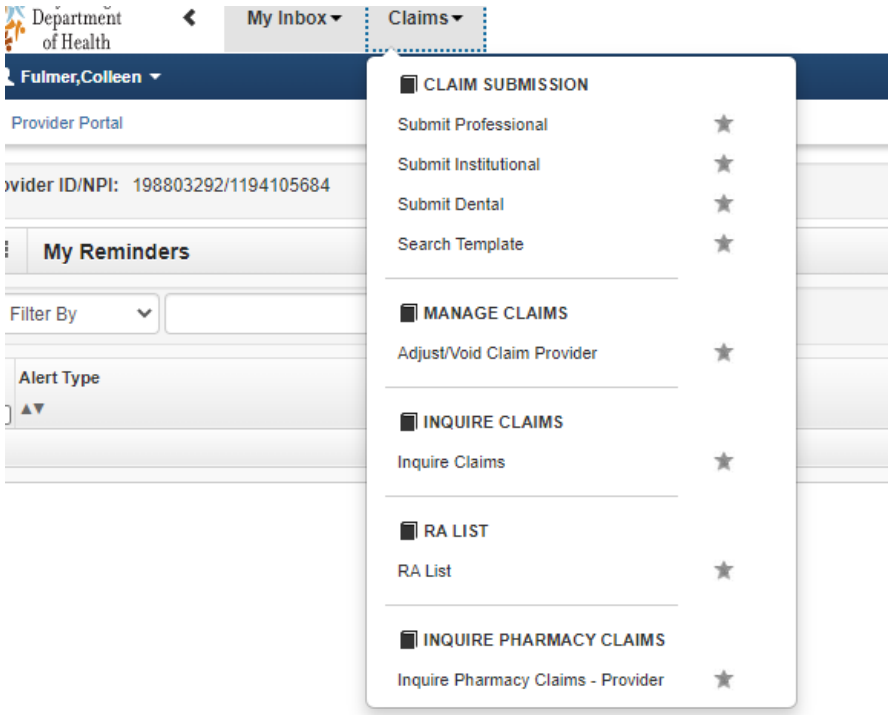
Adjustments for Billing

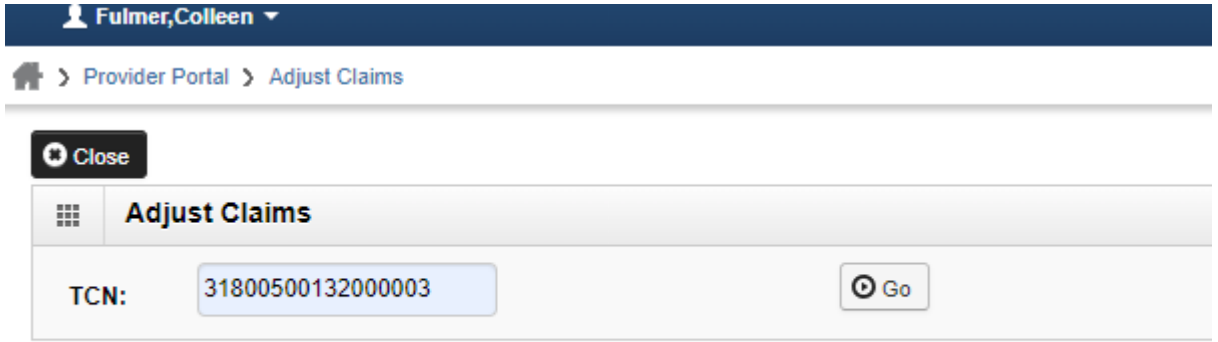
Adjustments- Signing on



- Select the domain
- Select “Claims Access”

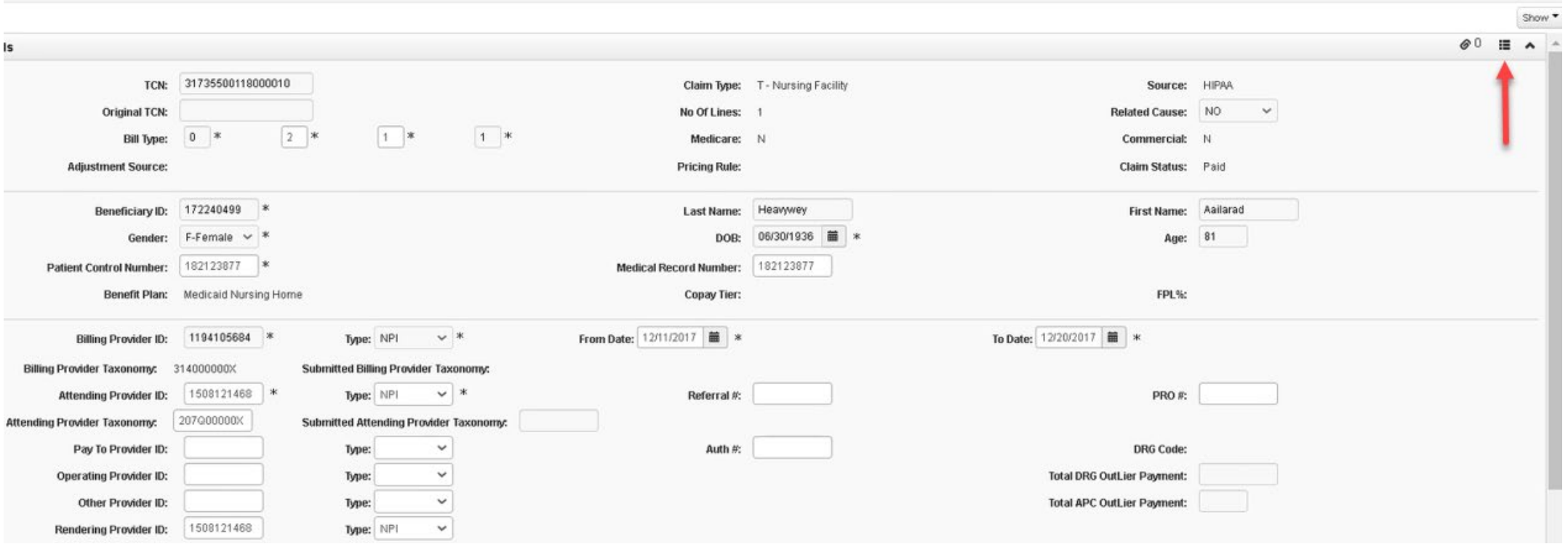
Adjustment-Claim Provider





- Select Adjust/Void Claim Provider
- Enter TCN to be adjusted

Adjustment- Line of the adjustment screen

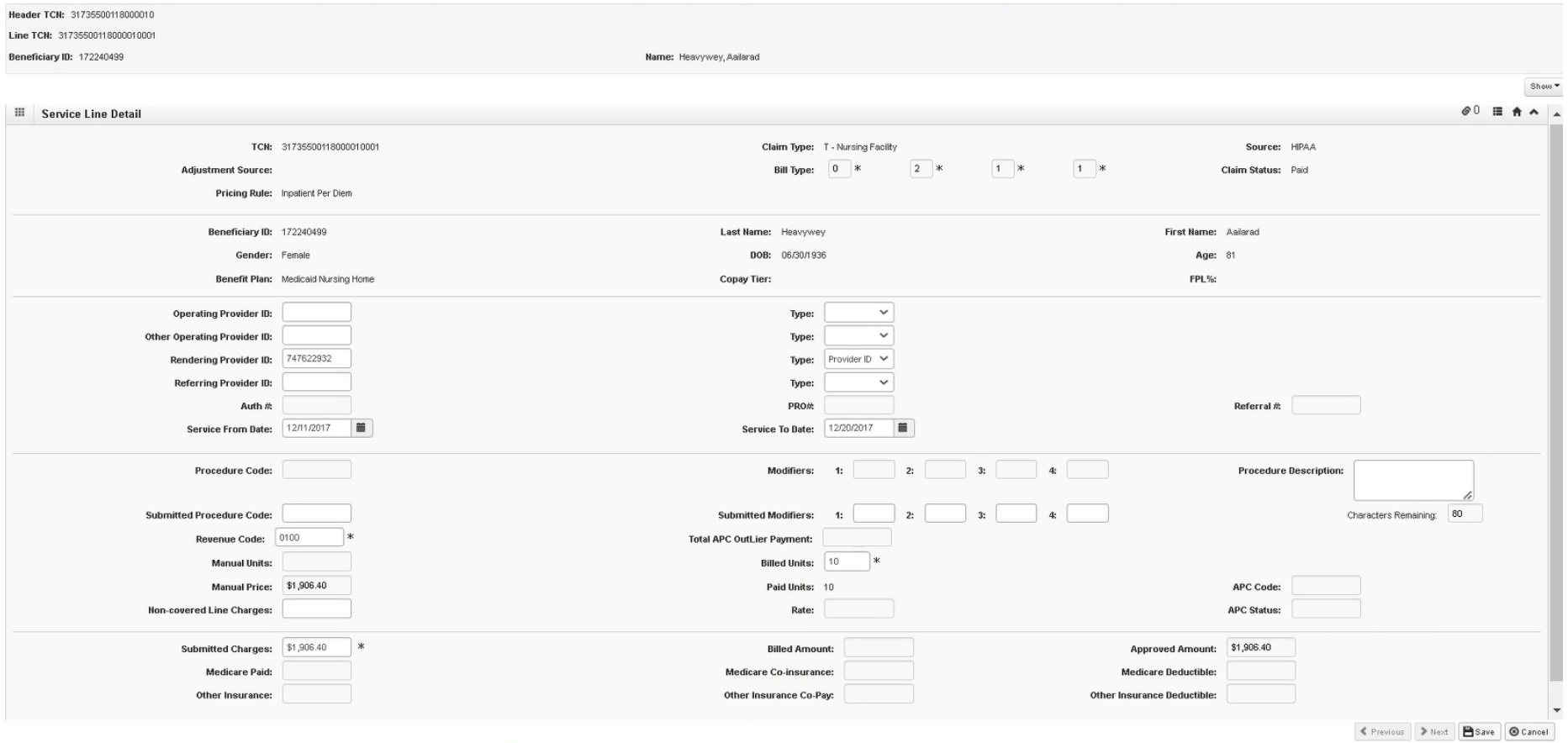


Go to the line level icon on the top right of the screen.
This is where the adjustment will start

Adjustment- Line Level Selection

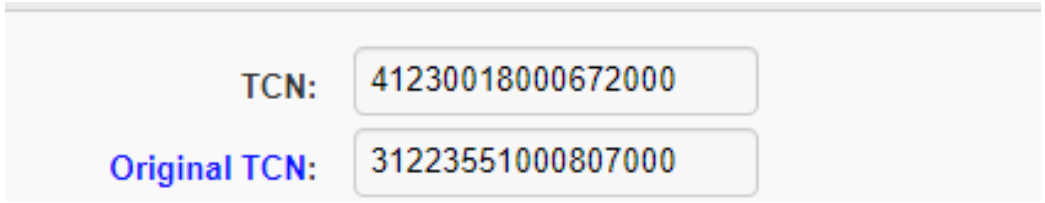
- Select the line that needs to be adjusted
- If there is more than one line, all lines can be adjusted on the same adjustment claim

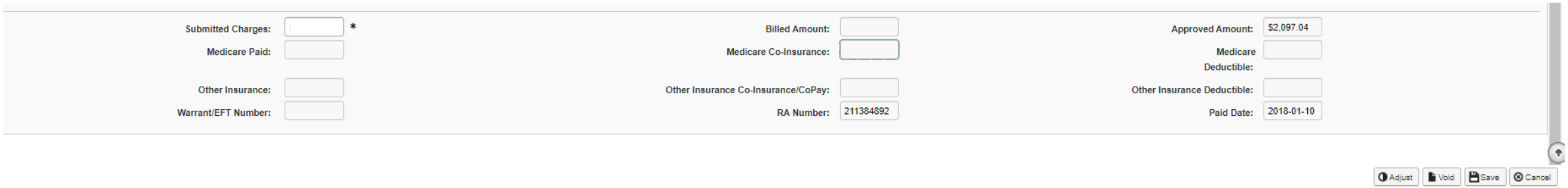
Adjustment- Line Level view



- Any box that is white can be adjusted
- Make the adjustment and click “Save” at the bottom of the screen

Adjustment- Header level





- TCN will change after making an adjustment
- Once the adjustment is done click Save and Adjust
- A box will populate. Select PIA and type a comment
- Select OK to complete the adjustment

Course Wrap

These topics were covered in the power point:

- Prior Authorization Look up
- Member Eligibility
- Attestation and LT101
- PASRR Information and PASRR I submission
- Value Codes
- Billing Examples
- Top 5 common denials and how to resolve
- How to bill a straight claim
- Error Codes
- Adjustments

Wyoming Department of Health

Thank you

Claim Submission